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ABSTRACT

This resource manual is designed to assist new and veteran board members in becoming effective and meaningful contributors to the community mental health center (CMHC) program. The materials summarize the growth and development of the CMHC concept and the services required by law and address the process of building and organizing the governing/advisory board, along with its functions, authority, accountability, and characteristics. Other chapters deal with board development and training, including training tools and resources. Evaluation and self-appraisal are also considered. A sample board constitution and bylaws are included. Throughout the manual the importance of citizen participation is stressed. (JAC)

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Orientation Manual for Citizen Boards of Federally Funded Community Mental Health Centers

This document was developed by
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FOREWORD

This manual comes at a time when citizen participation in Federal programs is seen as an essential link to the delivery of effective, efficient, and responsive services to all citizens. The direct participation of citizens and their respective community representatives in the development, implementation, and evaluation of community mental health center (CMHC) services can serve to strengthen the quantity and quality of mental health services. Participation is seen as potentially increasing the responsiveness, accountability, and flexibility of a program designed to serve the unique and diverse communities of our Nation.

Participation seeks to advance the right of every citizen to define and resolve the issues of importance in their community. Citizen roles in CMHCs take many forms. Their range includes serving on advisory/governing boards to volunteering to perform a variety of service functions in centers. Effective citizen participation requires a basic understanding of the mental health service delivery system, the concept of mental health, and the various roles, responsibilities, and functions of citizens as they assume the challenge of directing and influencing the CMHC program.

This resource manual was designed to assist new and veteran board members in becoming effective and meaningful contributors to the CMHC program. The right and responsibility to participate in and influence the many decisions that affect citizens rest with all of us. It is hoped that the challenges are accepted and the potentials realized as citizens succeed in making mental health services more accountable and effective in responding to the needs of their communities.

Herbert Pardes, M.D.
Director
National Institute of Mental Health

PREFACE

In the late summer of 1976, when I assumed the position of Chief, Citizen Participation Program at the National Institute of Mental Health, one thing was paramount in my mind: This program would have grassroot citizen input in its development. After struggling for some months with how to accomplish this, one primary issue emerged: Citizens and their representative boards needed essential information to become effective board members in their quest to develop, operate, and evaluate community mental health center (CMHC) programs. It was through exploring this critical concern that the idea for an orientation manual surfaced. The process to accomplish that objective was an exciting and challenging one.

First, people with expertise in citizen participation were identified. The following people made up the planning group: *board chairpersons:* Patricia Adrian and Margaret Steadman; *mental health consultants:* Mark Battle and Philip Wexler; *Institute staff:* Sherman L. Ragland, James A. Snapp, and Harlan K. Zinn. The seven of us spent many hours wrestling with this task. We decided that the most effective way to write a practical manual was to involve the potential users in the development and content of the manual. In September of 1977, a 3-day working conference was held in Annapolis, Md. The following people participated:

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The majority of the conference participants were selected to ensure that the 10 DHEW regions were represented by two CMHC board members. These individuals also represented urban as well as rural areas. A conscious effort was made to have a mix of male-female, minority, majority, governance, and advisory individuals. Every conference participant had input into the manual. The participants not only spoke for themselves, but represented their counterparts nationwide. Information exchanges and discussions were recorded verbatim by a reporting company. The recordings were then organized by my staff and Mark Battle, consultant, and subsequently released to all conferees for review and comment on accuracy and content. These comments and the draft document were reviewed by 12 of the original participants at another 2-day conference in January 1978 in Denver, Colo.

A final draft document was then developed. It was critiqued by seven well-known mental health leaders. This manual is the result of those efforts.

Many of the earnest and dedicated contributors will recognize their input. It is doubtful that each one would have made the same choice of procedure or language. We are grateful for the hard work and creative participation by the many people who participated in this effort.

Sherman L. Ragland, ACSW
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INTRODUCTION

This orientation manual focuses on the process of citizen participation in community mental health centers. It is not intended to be all things to all people, but it is designed to give citizens the basic tools and knowledge that are essential to becoming effective and efficient board members.

Who is this manual designed for? It is designed specifically for community people who have aspirations of becoming board members or those who already are board members and want to become more effective. It is not designed for the "professional" or "expert"!

What is its purpose? The purpose is to assist local citizens in becoming knowledgeable of and responsible for their community mental health center.

How is it organized? Chapter I deals with development and growth of the community mental health center concept. It provides a historical overview and concludes with a summary of the 12 essential services required by congressional mandate in Public Law 94-63 passed by the Congress in 1975. Chapter II focuses on the governing/advisory board, its functions, authority, and relationships. It begins with the citizen volunteer and concludes with the responsibility and accountability of the board and the community. Chapter III addresses the process of building and organizing the board. It starts with structure and concludes with some of the characteristics of a well-organized board. Chapter IV deals with board development and training. It identifies the reasons for board training and concludes with tools and resources for training. Chapter V describes the professional advisory board. Chapter VI discusses evaluation and the process of a board's self-appraisal.

Chapter I

The Beginnings and Growth of the Community Mental Health Centers Program

The Community Mental Health Center (CMHC), as we know it today, is a public or private nonprofit organization through which a full range of mental health services are provided to the residents of a clearly defined geographical area (catchment area). It has a governing/advisory body made up of residents who are representatives of the area. The CMHC is charged with providing services in a way that preserves human dignity and assures continuity of high quality care and which overcomes geographic, cultural, language, and economic barriers. A brief look at the background and the growth of mental health services shows how far we have come.

This chapter presents a historical overview, examines the Federal mandates since 1963, interprets the CMHC service commitment, and discusses the responsibility of citizens.

Historical Overview

Notions about mental illness have been traced far back before the Greek civilization of the third century B. C. In that pre-Greek period, evil spirits were given credit for the disorders of man just as the great gods were thought to be the origins of beauty and bravery. Hippocrates was the first to state the thesis that mental disorders had natural causes and should be treated as such. Plato is credited with presenting the notion of community responsibility to provide humane care for the mentally ill in the community. A short while later, the philosopher Aristotle suggested that mental disorders were a reflection of organic difficulties. At best, these insights led to humane treatment in pleasant surroundings and to a basic form of occupational and social rehabilitation.

During the 15th and 16th centuries, hospitals for the insane appeared in Europe. Colonial America, with limited medical resources, with great geographical isolation, and with a focus on survival repeated many of the harsh treatment methods practiced earlier in Europe. Some of the mentally ill were simply put away and fed periodically. Some were dunked, whipped, or executed.

As late as the end of the 19th century, confinement and isolation were still the primary approaches to the mentally ill. The "lunatic asylum" began to disappear only in this century. During the second half of the 19th century both professional and nonprofessional points of view came together around the notion that mentally disturbed persons are sick individuals requiring proper care.

Reforms

Within the first decade of the 20th century, psychology began to develop its own tools for the study of human behavior. At the same time, outpatient clinics and child guidance clinics began to emerge as multidisciplinary staff team approaches to treatment. One of the earliest indications of these community movements occurred in 1905, when social workers were first employed to provide clinical services to patients in neurological clinics in New York City and in Massachusetts General Hospital in Boston.

The year 1906 saw an early attempt to utilize the social worker as a means of hastening and of helping mental patients' readjustment in their communities, by the State

Charities Aid Association of New York. Three years later, the first completely developed community-based mental health clinic in the United States was established at the Chicago Institute for Juvenile Research. The year 1909 saw the establishment of the first guidance clinic, a traveling clinic with its headquarters in St. Lawrence State Hospital, in northern New York State. In 1910, the concept of the traveling clinic spread to Massachusetts; meanwhile, outpatient clinics were being established in the State hospitals of other States.

Despite this small stream of enlightened development, the continued accent on inpatient care increased the patient population in State mental hospitals under the worst possible conditions. Small budgets and insufficient staff prevented patients from receiving proper treatment or rehabilitative care. By the late 1940s, with the influence and impetus provided by World War II, many organizations joined the mental health movement. The number of service men returning home with emotional disorders and behavioral problems gave greater visibility to the mental health movement and underscored the need for better services. Major mental health professions developed their clinical roles more clearly and fully, including psychology, psychiatry, social work, and nursing. The Veterans Administration's involvement in mental health activities expanded dramatically by developing professional training programs and offering appropriate and accessible services. The States began to provide financial support for education, training and physical facilities.

In 1946, Congress passed the National Mental Health Act. This act authorized the establishment of the NIMH and made available funds for mental health research, training, and community-oriented services to the States and to private, nonprofit institutions. Now, for the first time, the concept of mental health had sanction in national health policy.

In 1955, Congress passed the Mental Health Study Act. This act stated as national policy the commitment of Congress to:

> promote mental health and to help solve the complex problems posed by mental illness by encouraging the undertaking of nongovernmental, multidisciplinary research and reevaluations of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill including research aimed at prevention.

In 1961, a report was published by the Joint Commission on Mental Illness and Health, a body which had been established by Congress to survey national mental health needs and recommend new treatment approaches. The report entitled "Action for Mental Health" had several results. It brought to the Nation a new awareness of the scope and nature of the need to improve mental health services.

Federal Mandates 1963 to 1975

Congress enacted the "Mental Retardation Facilities and Community Mental Health Centers Construction Act," in October 1963, which provided funding support for the construction of CMHCs.

The concept of mental health, central to the philosophy and structure of the CMHC program, was articulated in the 1963 Act. The conception was to create in every community a full and coordinated range of services available around the clock, close to home, for all in need. For the first time, prevention of mental illness and the promotion of mental health became important national community objectives. Treatment and rehabilitation of the mentally ill continued to be pushed as well. The main thrust, however, was that services be provided to a geographically limited area. The intent within this thrust was that services be accessible and available to those in need where they lived. Through this act the Nation made a commitment to assure the positive mental and emotional well-being of all Americans.

In 1965, Congress recognized the need for Federal funds to staff the CMHCs and provided such financial assistance on a declining 51-month basis. Less emphasis was placed on constructing new facilities for CMHCs in 1967, by permitting the authorization for the acquisition of existing buildings. By 1970, Congress realized the difficulties CMHCs were having in securing third-party payments (reimbursement from insurance companies) and local and State financial support to finance their operating expenditures when Federal funding ended. In response, Federal matching grant support was

extended to 8 years. At the same time, more money was authorized for State administration, new programs, training, evaluation, special projects, and consultation services.

Another Federal law, the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), had an important effect upon the planning of both mental health and general health services. The law established Health Systems Agencies (HSA) for specific geographic areas (Health Service Areas) for general health planning. The purpose of the HSAs is to plan for more effective delivery of health services and to examine the costs of health care. The boundaries of the health service areas unfortunately are not necessarily the same as the catchment areas used in mental health planning.

The Health Systems Agency is governed by a board having a majority of consumers. Included in the HSA authority is the power to review and approve/disapprove Federal grant applications. To be approved, proposals must be consistent with the regional Health Systems Plan (HSP). Leaders in both health and mental health planning are expected to begin to plan together. The long-term goal of joint planning is the avoidance of waste through duplication of facilities and programs and improved coordination of all health and mental health service programs. This is a difficult task for agencies that have not been used to thinking of mental and physical health together. Local mental health centers and State mental health agencies will want to assure that their goals are consistent with the State Health System Plan.

While Federal legislation requires State alcohol, drug abuse, and mental health agencies to prepare annual plans, it also requires community mental health centers to plan, coordinate, and deliver mental health services in their catchment area. Persons responsible for planning in the HSAs and in State and community mental health programs should be in contact with each other and begin to develop working relationships. Some examples of this mutual effort are: (1) formal representation of community mental health interests on HSA boards, (2) contracts or letters of agreement, (3) information exchange among mental health and HSA staff and/or committee personnel. (See Appendix E for a detailed listing of the planning functions of mental health and health planning agencies.)

In 1975, Congress passed P.L. 94-63. Under this act, CMHCs are required to provide 12 essential services:

(1) *Inpatient services* of a community mental health center must provide fulltime hospitalization. A full range of activities is to be offered, e.g., milieu therapy, psychotherapy, chemotherapy, recreational therapy, occupational therapy, and medical treatment when needed.

(2) *Outpatient services* must provide appropriate treatment so that clients can function as they go about their daily lives. Those services provided include diagnosis, evaluation, and treatment of psychiatric problems; and referral to other entities and agencies, as needed.

(3) *Partial hospitalization services* are treatment alternatives to full-time hospitalization. Whether in day, night, evening, or weekend services, the client is treated in a therapeutic environment while maintaining family and community ties.

(4) *Emergency services* to deal with immediate crisis situations must be available 24 hours a day, 7 days a week. Programs consists of 24-hour walk-in service, 24-hour telephone service, home visits, and services to other agencies. A mental health professional must be available at all times.

(5) *Consultation and education services* should be available to a wider range of individuals and entities including: health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities. They must include a wide range of activities designed to develop effective mental health programs in the center's catchment area, promote the coordination of the provision of mental health services among the various entities,

increase the awareness of the residents of the center's catchment area of the nature of mental health problems and available services, promote the prevention and control of rape, and provide proper treatment of the victims of rape.

(6) *Services for children* must be specialized programs including a full range of diagnostic, treatment, liaison, and followup services.

(7) *Services for elderly* must be specialized programs including a full range of diagnostic, treatment, liaison, and followup services.

(8) *Screening services* must be available to courts and other public agencies which are considering individuals for referral to a State facility for inpatient treatment. Screening services are designed to assess, plan for, and link individuals with appropriate services to be provided in the least restrictive setting possible. Where appropriate, treatment must be provided for such persons through the center as an alternative to inpatient treatment in a State mental health facility.

(9) *Followup care* must be provided for residents of the catchment area who have been discharged from a mental health facility.

(10) *Transitional services* must be available to mentally ill residents of the catchment area who have been discharged from a mental health facility and to those who would, without such services, require inpatient care. Transitional services must include appropriate living arrangements and the mental health and other supportive or rehabilitative services needed to help clients achieve or maintain community adjustment.

(11) *Alcoholism and alcohol abuse services* must be made available through the community mental health center for the prevention, treatment, and rehabilitation of alcohol abusers and alcoholics.

(12) *Drug addiction and drug abuse services* are a program for the prevention, treatment, and rehabilitation of drug addicts, drug abusers, and persons with drug dependency problems.

CMHC Service Commitment

The CMHC service commitment requires the involvement of a wide range of professional, paraprofessional, and support personnel. Working under a director, psychiatrists, psychologists, social workers, and nurses provide extensive direct clinical and administrative services. These professionals are assisted by a variety of other professional specialists: physicians, occupational therapists, recreation therapists, teachers, vocational rehabilitation counselors, mental health counselors, paraprofessionals, social work assistants, and hospital and psychiatric attendants, as well as center and community support persons (see Appendix A). All of these must be recognized as important resources available to consumers of mental health services at the CMHC.

The CMHC service commitment requires that the CMHC ensure the accessibility and accountability of a number of public and private providers and support organizations. These include such institutions as State mental hospitals, local public and private hospitals and clinics, family services agencies, settlement houses, and a number of consumer and community advocacy organizations. This required alerting and arranging for the participation of institutions and individual professionals and organizing a system of service providers that is designed to be responsive to CMHC referrals. It means giving particular attention to developing the operational contacts with community institutions necessary for effective prevention activity and necessary for the delivery of a complete range of treatment and rehabilitation services. It also requires appropriate recognition and linkage to the State Mental Health Authorities in terms of planning and financing of State-approved services.

The service commitment in a federally funded CMHC suggests that the center must be or become an integral part of the community in which it exists. This is to say that it must become an accountable institution, responsive to a set of identified community needs (see chapter VI), and dependa-

ble in the eyes of the citizens and other institutions of the community. It should be the leader in nurturing, maintaining, and promoting good mental health in the catchment area.

Citizen Responsibility

The concept of mental health, as reflected in P.L. 94-63 and as developed throughout the NIMH structure, is of critical importance in considering the functioning of governing/advisory boards. Operating policies adopted by such boards should provide direction, guidance, and boundaries for action leading to the realization of the goals of the CMHC. Stated another way, the CMHC goals must be expressed as objectives which permit clear planning, responsive operation, and qualitative and quantitative assessment. The objectives must be operationalized in a manner which admits to accountability and encourages evaluation. The achievement of these objectives by the center is a citizens' responsibility.

As federally funded institutions, CMHCs are required to assure community residents input on such things as goals, planning, policies, and operation of services and evaluation through the governing/advisory board mechanism. Thus, the *community* in the CMHC name is given vital meaning. The ways in which community input are utilized by the CMHC board and staff will have a great deal to do with the ultimate willingness of the community to assume responsibility for the ongoing existence of the center. Those CMHCs that have "graduated" from Federal sponsorship carry an ongoing obligation to their communities to embody the best in citizen participation. Analysis of their success will probably show the kind of citizen vested interest that reflects itself in increased local or State tax dollars and increased private contributions, which assures that financial requirements are met. However, it is the citizens who carry the responsibility to make certain that the CMHC becomes the responsive institution called for under the law. Working through their representatives on governing/advisory boards and working with the professional staff, the citizens can help shape the program, the operations, and the success of the CMHC.

Chapter II

The Governing/Advisory Board: Functions, Authority, and Relationships

The intention of this chapter is to identify and clarify the types, roles, authority, and functions of the governing/advisory board. It is also aimed at presenting and examining the relationship between board and staff. Particular attention is given to the executive director. The main thrust, however, is to highlight the citizen influence on the CMHC operation through participation in its governance.

The Citizen Volunteer

Volunteer citizen participation has long been recognized as a basic feature of the American character. Such citizen involvement and concern was underscored over 100 years ago in a book, *Democracy in America*, by Alexis de Tocqueville. He observed:

> These Americans are the most peculiar people in the world. You'll not believe it when I tell you how they behave. In a local community in their country a citizen may conceive of some need that is not being met. What does he do? He goes across the street and discusses it with his neighbor. Then what happens? A committee comes into being and then the committee begins to function on behalf of the need. You won't believe this, but it's true; all of this is done without reference to any bureaucrat. All of this is done by private citizens on their own initiative.

Today, millions of Americans devote countless hours annually to their responsibilities as volunteers in hospitals, social agencies, colleges, churches, etc. It is not possible to place a dollar value on all of the services citizens voluntarily contribute.

The Federal Government has given increasing recognition to the value of citizen participation and citizen control in the last 25 years. The notion of maximum feasible participation, which was mandated in the Community Action Program of the Economic Opportunity Act of 1964 and included in the Model Cities Program, has been assigned very clear and definite form in P.L. 94-63. That form is the full involvement of citizens on the governing/advisory board of CMHCs.

What Is a Board?

A board is a group of citizens organized as one body to govern. Where there is a charter under law the citizens, as a body, assume a legal trusteeship on behalf of the community. Under a trusteeship, an organization or activity is entrusted to the wisdom and good faith efforts of a group of concerned volunteer citizens. Today, in human service agencies in the United States, the board also serves as the trustee of society's decision to improve the quality of life of its citizens.

Boards may differ in authority and in activities from community to community. It is important, therefore, to be clear about the different types of boards and about the authority, functions, and roles of each.

Types of Boards

Two types of citizen bodies are permitted under P.L. 94-63: *governing boards* and *advisory committees*. The specific type required for a given CMHC, under this law, depends upon when the center became operative and its sponsorship.

Governing Boards

The kind of board primarily intended by P.L. 94-63 is the governing board. This board is also sometimes referred to as an "administrative" board, a "policymaking" board, or a "managing" board. A body called

a "board of directors" is, in fact, usually a governing board.

Under Section 201c(1)(a) of the P.L. 94-63, as amended, a governing board:

(i) is composed, where practicable, of individuals residing in the catchment area and who, as a group, represent the residents of the area with respect to employment, age, sex, place of residence, and other demographic characteristics;

(ii) meets at least once monthly, establishes general policies for the center including the hours during which services are provided, approves the center's annual budget, and approves the selection of a director for the center; and

(iii) has at least one-half of its membership composed of persons who are not providers of health care services

In carrying out their policymaking roles as members of CMHC governing boards, citizen/residents of the catchment area exercise their influence on the operation of the CMHC.

Other conditions in the description of governing boards included in the legislation were designed to take into account instances in which the governing board of the CMHC might be in conflict or competition with the organizational structure of its sponsor. Such could be the case when a CMHC is sponsored by an agency of the local government or by a hospital or university, each of which has its own top level governing structure.

Under such circumstances, the intent of the legislation is not to ignore or to challenge the authority of the hospital or university board. The fact remains that policies and constraints imposed by the governing boards of such sponsoring organizations are binding on the CMHC board/committee, unless they conflict with the requirements of Federal legislation. In order to assure that CMHC boards, involved with such dual governance structures, are assisted in fulfilling the responsibilities mandated by the legislation, the Division of Mental Health Services of NIMH has outlined the following alternative arrangements.

Option 1: Delegated Responsibility

The board of trustees of a sponsoring hospital or university or other organizational structure may delegate the legislatively required responsibilities and functions to a representative governing board for the CMHC.

This option allows the existence of two autonomous boards as noted:

(a) A community board meeting the requirements of the Act, responsible for establishing general policies for the CMHC Program, approving the budget and expenditures of funds, and approving the selection of the CMHC director.

(b) A superordinate board which does not necessarily meet the requirements of the Act, with oversight responsibilities.

Option 2: Interlocking Board

The sponsoring organization governing board may delegate authority as in Option 1 and may, in addition, assign one or more of its members to serve on the CMHC board. In this case, the residence requirement for board members could be waived under the "where practicable" clause. Care must be taken, however, to not exceed the 25 percent limit on nonresidents of the catchment area and the 50 percent limit on providers of health care services as members of the community board. This option may be very desirable for hospitals since it affords a direct opportunity for participation in policymaking.

Option 3: Subcommittee

If Options 1 and 2 are not deemed to be feasible, the board of the sponsoring organization may wish to establish a subcommittee to serve as the governing board of the CMHC. The composition of such a subcommittee/board must be consistent with all of the legislative requirements. As a subcommittee of a superordinate board, it must function within the policies and constraints of the board (where they are not in conflict with P.L. 94-63) and relate to the superordinate board on significant matters pertinent to the CMHC.

Option 4: Program Transfer

Under this option, the sponsoring organization board may agree to transfer the grant to the CMHC governing body. This procedure establishes the CMHC as the grantee and transfers all legal and fiscal

responsibilities. Under such an agreement, the previous sponsoring agency may elect to retain some involvement in the program by providing services through purchase agreements.

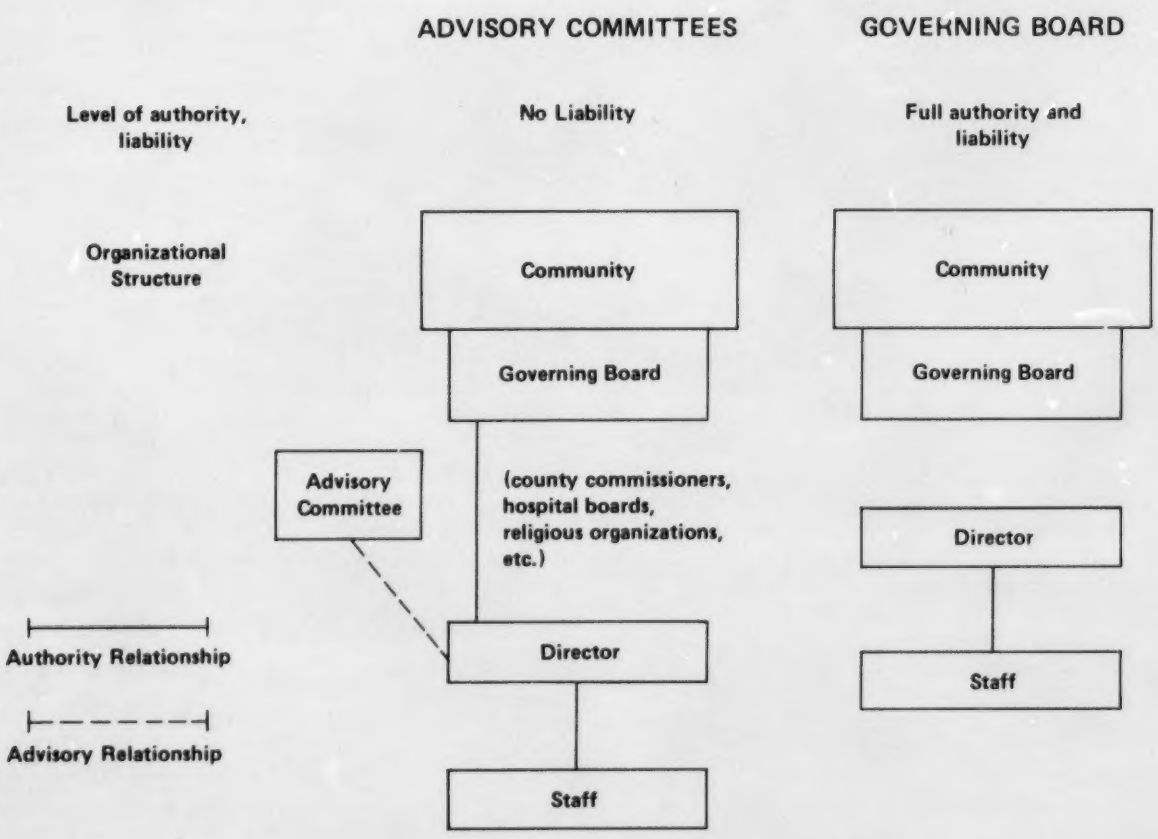
ADVISORY COMMITTEE

CMHCs, sponsored by State or local government agencies which were already in operation and had received a staffing grant prior to the enactment of the 1975 amendments, are not required to establish a governing board. Rather, such centers must establish advisory committees composed of representatives of catchment area residents. At least one-half of the membership of these advisory committees must be persons who are not providers of health care services. Whatever their formal structure, they do not *make* policy, they *advise* on policy; they do not *make* financial decisions, they *advise* on fiscal matters. Advisory committees are generally established to serve one or both of the following purposes:

a. to provide a mechanism whereby input representing perspectives which might otherwise go undervalued or unnoticed is assured; and/or
b. to provide a mechanism whereby technical, professional or specialized expertise is made available to the actual ultimate governing body.

Even though it must be recognized that an advisory committee has no statutory or legal authority, it is important to appreciate the power such groups may command. The widespread community support and expert knowledge which advisory groups can bring to bear may be powerful forces in the policy-making arena.

COMPARISON OF ADVISORY COMMITTEE AND GOVERNING BOARDS



TWO BOARD STRUCTURE

Under some circumstances, CMHCs have both a governing board and an advisory committee. Care should be taken in these situations to be clear about the differences in roles, relationships, and authority of each. It must be clear, for example, that the advisory committee is subordinate to the governing board. The advisory committee, in this situation, might be restricted to giving its attention to the services of the CMHC, while the governing board focuses on general management and fiscal affairs. The possibilities for making a clear differentiation are many. The apparent advantage of the two-board structure lies in the opportunity it presents for broader citizen participation in the policy-planning and decisionmaking processes of the CMHC.

Members of boards should be aware of the dual role of the board: Its management responsibilities for efficiency and completeness of programs; and its responsibility for good continuing relationships with the community. The board's mission is to make sure that programs are run well, that services are being delivered, and that money is managed properly. In addition, services must be responsive to the concerns of the community. This dual role is referred to as the tightrope the board must walk. As part of its management role, the board is the place where the buck stops. The board is in control, and the staff ultimately work for the board. However, the board must never overlook its responsibilities for representing the community.

It should be stressed that the board role is to act as a "body." Board members act on behalf of the board rather than as individuals. Careful attention should be focused on the distinction between acting as an individual advocate and acting as the voice of the board on behalf of the CMHC.

Governing boards have legal responsibility and are accountable for all aspects of the business of the CMHC. P.L. 94-63, Section 201, requires as a minimum that the governing board assume the responsibility to:

> Establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the Center.

The responsibilities for overall planning, for general management, for evaluation of operations, and for community coordination are clearly indicated. Some parts of these responsibilities are specified as ongoing functions of the board in the next several pages. Some may be specifically delegated by the board to the executive director.

FUNCTIONS OF THE BOARD

The major groupings of activities of the board of a CMHC are called functions. A listing of those functions are:

1. *Legal.* It is the function of the board to secure the establishment and maintenance of the legal or corporate existence of the CMHC. The board should periodically review the charter, constitution, bylaws, and other documents which establish the legal status of the center. Depending on the applicable Federal, State, or local regulations, certain elements (such as nonprofit status) may have to be renewed or revised.
2. *Needs Assessment.* It is the function of the board to make certain that the service delivery priority decisions made by the CMHC are based upon:
   a. an assessment of the needs for service which exist in the catchment area (see chapter VI).
   b. requirements of funding and regulating agencies like NIMH and State mental health authorities. Where differences appear, the board may need to negotiate in order to assert its views on behalf of the community need. In order to perform its function, the board will need to:
      (1) participate in planning for the needs assessment
      (2) assure resident participation in the needs assessment
      (3) review the findings of the needs assessment for accuracy and usefulness
      (4) require periodic updating of the information
3. *Planning for Board Operation.* It is the function of the board to develop a

plan for its own operation each year. Such a plan should include a clear identification of the *objectives* it will seek to achieve, how it will achieve them, and the cost and staff service necessary. On the basis of this plan, the board can operate during the year relatively smoothly in coordination with other parts of the CMHC. At the end of the year the board can evaluate itself on the basis of performance against its plan.

4. *Policymaking.* The board must establish agency objectives, as well as administrative policies, which will serve to guide the CMHC. This function includes the responsibility of the board for the long- and short-term service planning of the CMHC. It suggests specific use of the information collected in the needs assessment as a base for policy planning. Ultimately, the policymaking function calls for particular collaboration with the staff of the center to assure appropriate and necessary staff input. This set of activities can significantly reinforce the community's confidence in the board's ability to deliver on their behalf especially if they, the citizens, are included as often as possible.

   Policymaking can be viewed from a variety of points of view. Involvement with "administrative policies" usually refers to the running of the center. General policy statements provide the base from which the board can express public approval or disapproval on current issues before the grantee, legislative bodies, and elsewhere, affecting the CMHC. The director should have specific but limited participation in the formulation of policy. The role is to anticipate problems that need policy positions and, with the help of the staff, present those problems to the board. Further, the role includes providing the staff service the board needs to arrive at decisions, e.g., research analysis and recommendations.

   The executive director does not make the policy; rather, policymaking should be a joint venture with the board, the director, and the staff. However, the board must do more than merely respond to the issues presented by the director. The board must take the initiative in making policy. In other words, the board should aggressively protect its responsibility for policy decision-making, planning, and priority setting.

5. *Fiscal Management.* The board carries three responsibilities within its fiscal management function. It has the responsibility for planning and establishing all of the fiscal policies necessary for an efficient accountable operation. This includes budget policies, fee policies, fiscal year timing, ceiling determinations, if any, and the kind of budget. It includes accounting policies like the kind of accounting system and selection of an auditor. It includes cash management policies such as the selection of a bank, specific investment plans, designating loan authority and signature authority on checks.

   The second board responsibility in fiscal management is the budget development and the approval process. Approval of the budget is the authority of the board solely. However, budget development is an activity shared with staff.

   The third board responsibility in fiscal management is in fund raising and the assurance of sufficient monetary support to meet the service commitments of the center. The board alone has the legal authority to enter into contracts and receive grants and other funds. However, it may delegate parts of this responsibility to the executive director.

6. *Public Relations.* The board has the function of public relations and, thereby, interpretation of the center's services to the community. Board members, as representatives of the center, are symbolic of the highest authority and thus must be careful to carry out this responsibility ethically and sensitively. This includes relating to the media, to individual citizens, and to the local and State political processes. The primary purpose is to keep the board visible, accessible, and accountable to every citizen in the community.

Boards should have in their ranks those who have access to the media for information purposes. Good media relations will make it possible to take advantage of free publicity through public service programs. Boards should maintain good communications with specific organized groups such as fraternities, sororities, community service groups, churches, social groups, ethnic and minority groups, tribal councils, and so on.

External relations could go even further. Boards should become familiar with some of the common criticisms directed at their center by way of a formalized mechanism. Specific local criticisms may be handled by a committee which answers inquiries and responds to criticism rather than by the center director. Board members may have more credibility with critics than the director.

7. *Advocacy.* The board is charged with advocacy of the community's interests and needs in its own deliberations and in its dealings with other social service agencies and governmental bodies. In this responsibility, the board represents the catchment area. It thus asserts the CMHC community service commitment and its own accountability for delivery of the goals of the mental health concept. The board's relationship with local and State legislative bodies is broadly defined as being part of the board's responsibility to create a favorable political climate for the center's delivery of services and for the provision of funding for the center. Politics should not be seen as a "dirty word," since it is in fact the bottom line for survival. Advocacy in this sense is a perfectly respectable activity which entails board members getting to know the legislature and encouraging political involvement in the center's program. One way to do this, for example, would be to hold a "Mental Health Day" to which local politicians could be invited. Another is to have a sensitive local legislator as a member of the board.
8. *Community Coordination.* Communication and cooperation with other agencies serving the community are important board activities. The board recognizes that the CMHC is one agency among many in the community. It should give leadership when appropriate and participate in the building of a community-wide service system. Participation with the HSA referred to in chapter I is an important part of achieving a coordinated community-wide system of services.
9. *Evaluation.* Regular evaluation of the center's programs, processes, policies, and its own effectiveness is a specific function of the board. The evaluation role is described more fully in chapter VI. This is the foundation role for much of the activity of both the board and the center.
10. *Selecting the Director.* One of the most important functions of the board is approving the selection of an executive director for the center. This begins by knowing and specifying the tasks and functions that an executive director will be expected to perform, and by writing an appropriate job description. In such a description there should be a clear-cut statement of what responsibilities and power will be held by the board. In general, it is good practice for the board to delegate full authority and responsibility to the executive director for *operations* of the center.

    The board must expect that the director will assume responsibility for keeping the board informed with information and data to monitor the director's work and the work of the center. Thus, the board can be sure that the activities and services of the center are consistent with board policy.

    The board, functioning as a whole, in committee, or as individuals, should work *through* the director to implement policies.

    As part of the board's responsibility to the director, it should be prepared to review and evaluate the director's performance at least annually. The board

should also make sure that there is sufficient appropriate communication to allow the director to represent the board effectively and responsibly.

RESPONSIBILITIES OF THE EXECUTIVE DIRECTOR

The executive director of a CMHC is the number one manager of the board.

The executive director of a CMHC has five basic functions through which he/she executes the board's policy mandates and plans. They include *planning* the implementation of policy; *organizing* all elements of the center to implement policy; *mobilizing* and *motivating* personnel to implement policy; *controlling* the implementation of policy; and *evaluating* the implementation of policy. The NIMH Task Force on Organization and Governance of 1973, concerned with the training of mental health administrators, developed the following list of activities through which the executive director carries out his or her functions:

1. Exercises authority role appropriate to the position
2. Assures that the service needs of the catchment area population are identified
3. Identifies the cultural context in which services are to be delivered
4. Develops and obtains resources (funding organizations, personnel, and space)
5. Develops, coordinates, and distributes resources
6. Plans methods to meet management needs
7. Stimulates programs and is a catalyst for staff and community
8. Creates and implements innovative approaches in program and organization
9. Monitors and evaluates the total operation including services
10. Expedites the resolution of malfunctions and removes barriers to the delivery of services
11. Coordinates the personnel talents and professional disciplines needed to serve clients, staff, and community
12. Resolves intra- and interprofessional differences in services.
13. Adjudicates treatment modalities and priorities where necessary
14. Advocates for the staff
15. Advocates for the rights and needs of the mentally ill
16. Advocates for the mental health of the population
17. Relates to internal and external political processes and patterns
18. Interprets facility functions to the community and the individual and is a channel for community and client reaction to the program
19. Insures participation of staff, patients, and community in program and policy decisions
20. Facilitates education of (inservice and formal training) staff, superiors, and boards
21. Insures accountability to the public
22. Relates to the media and is responsible for the public relations program

Both the length and nature of this list suggest some of the dilemmas and challenges which confront the executive director of a CMHC. He is unquestionably the man in the middle, negotiating and resolving the diverse needs and expectations of the board, staff, clients, and community. This same task force made the following recommendations regarding the executive director's responsibilities:

The center shall be organized and administered so as to allow for the:

1. implementation of programs, policies, and priorities established by the governing authority
2. performance of management functions which will assure that program services will be available, accessible, acceptable, and coordinated to promote continuity of care.
3. clearly defined delegation of authority and accountability for program functions to center staff who are assigned managerial responsibilities
4. coordination of activities with other governmental and private groups concerned with the planning and delivery of health and social services

STAFFING THE CMHC

The development of the staffing pattern is a responsibility of the executive director. The board in its planning and evaluation function can obtain consultation from a number of sources to assist in reaching policy determinations about the staffing. (See Appendix G.)

There is considerable variability among CMHCs in terms of staffing patterns. However, mental health professionals such as clinical psychologists, clinical social workers, psychiatrists, and psychiatric nurses are represented. Other professional and nonprofessional staff are also found. The specific work done by those staff members cannot be predicated on professional discipline alone, since current practice reflects fairly broad and overlapping boundaries. However, boards should recognize that licensure requirements, national and local certification may limit selected functions to certain professions. The specific composition of the staff in regard to professional discipline, training, and experience will be influenced by the following:

1. Requirements of regulating agencies such as State and local mental health authorities
2. Licensure and certification requirements
3. Program design and service delivery strategies
4. Community expectations and norms of professional practice

BOARD-STAFF RELATIONS

In an ideal situation, board members and professional staff perform their tasks in a complementary manner in order to achieve the center's objectives. The practical methods described here are ways of increasing mutual understanding, cooperation, collaboration, and coordination of efforts between board and staff members.

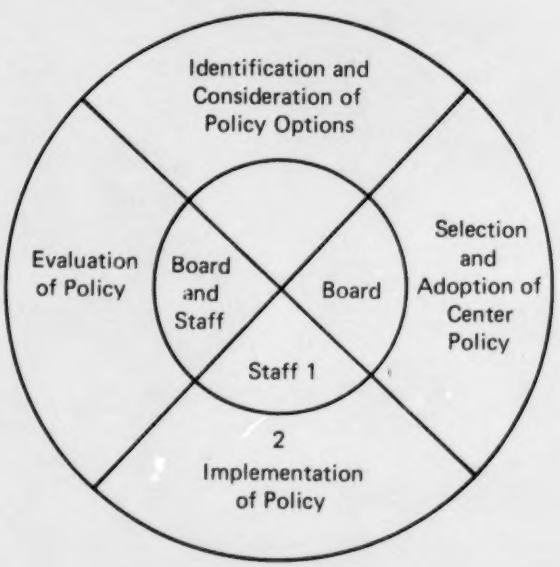
Positive relationships between board and staff are encouraged by common understanding of several basic notions:

1. Board and staff members share a common commitment to assuring the achievement of the center's objectives.
2. Each group brings specific roles and special resources to the common task.
3. Board members and staff members, in the common task of pursuing the center's objectives, constitute a team.
4. Board and staff members have both separate and shared responsibilities.
5. Adequate, appropriate, and accurate communication between board and staff is necessary to successsful attainment of the center's objectives.

The major areas of conflict between board and staff frequently revolve around the issue of authority. Clarifying the roles and responsibilities of each group must be an ongoing effort based on sound and consistent principles rather than a matter of whim or expediency. There is general agreement that the basic distinction between the roles of board and staff may be summarized in a phrase—the board makes policy; the staff implements policy.

Figure 1 shows both the process flow and the appropriate center of responsibility.

Figure 1
The Policymaking Cycle



A problem which sometimes arises, even when such a procedure is adopted, involves the intrusion of board policy decision on professional discretion. In order to allow staff the maximum opportunity to use their

professional expertise, board policy should be expressed in the broadest terms wisdom permits. Staff are then able to consider options and determine the appropriate method of implementation. On the other hand, staff are obliged to remain faithful to the intent of board policy. Ultimately, the program evaluation process which is the joint responsibility of board and staff will reveal both the wisdom of the policy and the appropriateness of the methods selected for its implementation.

The board should make certain that there are clear personnel policies, including a grievance procedure, that are accessible to every employee. Staff members should not be on the board.

There are many methods for facilitating positive and productive relationships between boards and staff members. Listed below are 10 practical approaches which have proven to be helpful.

1. *Staff Directory.* Each board member should be provided with a directory of personnel and the program units to which they are assigned, with additional attention given to those persons identified as key members of the staff.
2. *Board Directory.* A directory which provides a profile of each board member should be made available to all staff members.
3. *Staff Observation of Board Meetings and Board Observation of Staff Members.* While not necessarily a matter of routine policy (though consideration might well be given to such a notion), opportunities for observation may serve to open doors of communication and understanding. Self-discipline is an obvious requirement.
4. *Regular Exchange of Minutes or Summaries of Actions of Board and Staff Meetings.*
5. *Joint Training Institutes.* Such experiences may be particularly appropriate when the center is considering the implementation of a new program.
6. *Annual Joint Planning Conference.* This provides an opportunity to review the center's goals and projected programs for the coming year.
7. *Annual Joint Evaluation Conference.* An opportunity for assessing achievements and failures together.
8. *Overlapping Orientation for New Board Members and New Staff Members.* An ideal opportunity to underscore the notion of partnership and shared commitment.
9. *Special Project Committees.* An opportunity to share skills and interests, particularly those which might not be evidenced in regular center programs.
10. *Informal Social Events.* An opportunity to develop one-to-one social relationships outside of the pressures of the work environment.

BOARD AND EXECUTIVE DIRECTOR RELATIONS

It is crucial to the successful function of the center that the board establish an effective relationship with the center director. The director, in his role as the executive officer, is the instrument through which the board's policies are carried out.

Opportunities for extensive and candid communication must be provided on a scheduled basis. The relationship must be based on mutual respect and confidence of each in the ability of the other to carry out responsibilities.

In this context, it is important for the board and the executive director to recognize that the wishes of the board are expressed through the chairperson, while the daily direction of the center is charged to the director. Therefore, actions which are intended to guide the center director or bring matters to the attention of the board must follow formal and agreed-upon procedures. Board members as individuals should not intervene in center activities through the director of staff; rather, this should occur as a result of board action expressed through the chairperson. Conversely the director must not undermine the role of the chairperson and the structure of the board by approaching individual members without the awareness of the chairperson. This is not to suggest that communication between the center director, staff, and board

members should be totally prohibited. It is to suggest, however, that discretion must be exercised to assure that policy, direction and center leadership are not compromised by independent actions, no matter how reasonable the motivation.

THE BOARD AND THE COMMUNITY

Membership on a board implies advocacy and carries with it the responsibility to communicate with and be supported by the community. The board must be able to represent the community; it must assume that the community is willing to support the board as its representative. To accomplish this, communication must flow freely between the community and the board; and this flow of communications also will result in an opportunity for increased recruitment from the community to the board.

Merely telling the board members, however, that they have a dual role of management and advocacy is insufficient. Board members must know of their responsibility to see that the needed mechanisms are established and that they work. Although an elected governing board may not have its functional link to the community spelled out, its members should stay attuned to community discussion on issues affecting the CMHC and the community.

Chapter III

Building and Organizing the Board

This chapter focuses on elements and issues involved in building and organizing CMHC governing/advisory boards. It deals with the structure of boards and the process of organizing. A number of issues are discussed which are important to the work of governing/advisory boards and to involving citizens in the operation of CMHCs.

BUILDING THE BOARD

CMHC boards may secure candidates for membership in a variety of ways. Some appoint a nominating or search committee to recommend candidates for board membership. The model used in this manual is a board membership committee responsible for all elements of the board-building program. Such a committee should be composed of representative, experienced, and capable board members since its mission is one of the most important in the organization.

The central principle of board building is that the structure must serve the function. In a CMHC, the primary function of the board of directors is to provide policy direction and to make certain that there is effective and efficient service delivery. Therefore, decisions regarding structural elements (size of board, terms of office, etc.) and process elements (recruitment, selection, and orientation of new members, etc.) must be designed and operated so as to build the center's ability to delivery services and thus achieve its mental health objectives. The details of these are presented in the pages which follow.

STRUCTURAL ELEMENTS IN BUILDING THE BOARD

The basic structure of the board and of the organization should be laid out generally in the constitution (charter) establishing the CMHC and specified in the bylaws which are the operating rules adopted by the board. However, options in structure, organization, and processes do exist. Some of them are presented here.

Board Size

The issue of board size is very directly related to the question of structure serving function. There are two basic functions which suggest different forms. The function of making policy for a center, consistent with the view of that function as a trust, requires that broad community interests be represented and thus suggests the establishment of a relatively large board. The functions of problemsolving and operations decisionmaking, on the other hand, are more effectively served by a relatively small group. A further consideration is that increasing the size of a group tends to make it more difficult to develop and sustain a sense of group togetherness and to avoid feelings of isolation. Ordinarily board sizes vary from eleven to thirty members. The board should establish whatever structures are necessary to carry out its functions. However, it is because of board size issues that the board committee structure has evolved.

Term of Office and Rotation

The CMHC may be seen as a delivery system in a rapidly changing environment. Just as the needs of the community change, so do the needs of the center and its board. Fresh ideas and points of view renew the system's vitality. Thus, regular and planned change in board membership is highly desirable while preserving continuity.

A common and effective practice is to establish 3-year terms of office with provision for renomination to a second full term.

Terms are staggered so that one-third of the board is elected or appointed each year. This combination of limited tenure and rotation provides for both continuity and change.

It is desirable to make certain that, at any time, catchment area representation on the board is maintained at an appropriate level. Careful tailoring of the rotation system can assure this.

PROCESS ELEMENTS IN BUILDING THE BOARD

There are at least seven phases or subprocesses in building a board. They are membership needs assessment; identification of prospective board members; screening candidates; recruitment, election and appointment of new members; orientation; recognition; and termination of service.

1. Board Membership Needs Assessment

Each opening on the board represents an opportunity for enriching the center, setting new directions, and developing new leadership. Just as programing new services is based on a needs assessment of the community, so too should the board membership process be based on a needs assessment of the center, its board, and its committees.

The nature of the major issues facing the center now and those which are likely to be important during the tenure of the board members to be selected should be first among the criteria for setting the targets of the board membership committee.

The second major consideration is the need for active participation within board membership. Each board slot is a valuable resource. Therefore, while prominent citizens may add lustre, unless such individuals are willing to participate actively and undertake their share of responsibility, such appointments are ultimately self-defeating to the center. Some organizations have resolved this common problem by establishing an honorary board of governors. Such a group serves as a vehicle for honoring distinguished citizens, thus assuring that the actual governing board may remain a working board.

The third issue is the matter of assuring catchment area resident participation in governance and thus assuring two-way communication and advocacy. This suggests the need to have members who are committed to representing the area in the deliberations of the board.

The major sources of input for the membership needs assessment phase are board discussion, staff observations, and reports from committee chairpersons. It is the responsibility of the board membership committee to blend this input into an understandable set of guidelines for its own procedures in identifying prospective board members.

2 Identification of Prospective Board Members

The CMHC exists within a specific community environment. There are a variety of interest groups and forces within that environment which affect the center and which may be influenced by the center (e.g., religious, ethnic-social, political, and economic groups and forces). The center must find a way to include people embodying all of these groups and forces within itself. Thus it can avoid becoming an exclusive system and become truly representative. Failure to assure such representativeness in the composition of the board will result in a shortage of resources as input to the center in the form of information, money, volunteer personnel, clients, etc., from the community. Such a failure will limit program achievements, responsiveness, accessibility, and credibility in the community.

With these considerations in mind, the board membership committee should develop a list of potential board members by requesting recommendations from past and current board members, program volunteers, formal and informal community groups, and center personnel. It is particularly important that community, social, religious, civic, and fraternal groups be considered when seeking ethnic minority group participation. Such groups exist in every community.

The composition of the board should be balanced and representative. A balanced board would also include persons of different skills and personalities. There should be a balance of economic and social backgrounds, age, and particular geographic

representation from within the catchment area to the extent possible.

The CMHC statute provides some direction for citizen participation, but boards can be more specific and firm in their own guidelines. For example, there should be a cross-section of the community, not just business people. Some communities select their board members from those who attend three out of five town meetings to demonstrate their interest in the area, in addition to living in and being knowledgable about the area. A board should be concerned about the individual's background and reputation for involvement in the community. On the other hand, there should be an opportunity for the inexperienced to become involved in the center's affairs.

A truly representative board is able to communicate directly and easily with its community. This happens in part because such a board is made up of members suggested by constituent groups in the catchment area. It happens also because individuals are identified and selected who are found to be positively involved in the life of their community. Achieving a balanced board also requires finding members representative of the minority and female populations of the area.

Trying to be representative and at the same time an effective governing body can be difficult. Indeed, at times representation may seem to be secondary to governance. Actually such a notion is an unreal conflict. Representation deals with the primary makeup of the board, while governance deals with the mission of the board.

3. Screening Candidates

A screening committee should examine potential board members in order to secure the best talent available. Recommendations to the board membership committee must include basic information about the individual. Each person recommended can then be evaluated against the criteria established during the needs assessment phase of the process. Some basic measuring rods are suggested by the following questions:

> Does the individual possess interest in mental health, as well as the relevant knowledge and/or experience to make meaningful contributions toward achieving the center's objectives? Is the individual willing to be trained?

Often, the first question includes the phrase, "qualified individual." Though such a term sounds appropriate, it has too frequently been used, either intentionally or inadvertently, to prevent consideration of individuals who might well have proven themselves to be valuable board members. "Knowledge" may imply expertise in a particular content area, but it also must mean familiarity with the mental health needs of the catchment area population.

> Is the individual able and willing to give the necessary amount of time and effort to board responsibilities?

Just as accessibility is a cornerstone of the community mental health center effort, so too the board must consider its own accessibility. Board meetings and activities must be scheduled at times and places which allow for the greatest participation. Potential board members should be judged in part on the answer to this question. They should understand their attendance will be recorded and their participation evaluated.

> Does the individual possess the personal skills and attitudes which will enable him/her to function effectively as a board member?

Some of the most important personal skills which a board candidate should possess include: (a) the ability to work effectively with others; (b) the capacity for learning, study, and growth; (c) the courage to speak on behalf of one's convictions in spite of the fact that the majority may disagree; and (d) the ability to accept and work with decisions made by the group. Though only preliminary assessment of these skills can be made prior to personal meetings during the recruitment phase, the initial recommendation should reflect some of these characteristics.

RESTATEMENT OF QUALIFICATIONS

Things to look for in identifying and screening new board members may be restated in the following ways:

- A sincere interest and commitment to mental health
- Demonstrated concern that the services meet the needs of the people in the catchment area
- A willingness to commit time and effort to board service

An awareness, before accepting service, that the board is a working and active group

Some community influence and a working relationship with citizens who may be influential in obtaining funding and community support

Sensitivity to, or experience in, community politics

Demonstrated leadership in local organizations which have the potential for providing support to the center

Some knowledge of business and public financing

Dedication to community service

Respectability in the community

Personal integrity

Concern for human beings

Civic mindedness

Desire to be well informed on issues which affect the center

Willingness to serve the community

Although a single prospective board member need not have all of the above qualifications, the board itself should embody and reflect all of them.

4. Recruitment, Election, and Appointment of New Members

Recruitment is ultimately a face-to-face procedure. A recruitment team composed of a board member and a staff member should arrange for an appointment with each individual being considered. The purpose of the recruitment meeting is *not* to finalize an agreement that the individual will, in fact, become a member of the center's board. It must be clearly indicated that election and confirmation of membership are a board function. What should occur during the recruitment meeting is the gathering of additional information for the final consideration by the board membership committee prior to making recommendations to the board. The meeting should also include a determination of the individual's willingness and availability to serve. The recruitment team should be prepared to: (a) acquaint the prospective board member with the center's objectives; (b) identify the expectations which the board has for each of its members and explore possible roles and commitee assignments for this individual; (c) provide accurate information regarding time and service requirements; (d) define the possible benefits to the individual from his service; (e) answer questions that prospective board members may ask.

Election of new members should take place at a board meeting. Subsequently, a letter of election or nonelection should be sent by the chairperson of the board. Where appointment by the local government is the final step in the process, the appointing authority may wish to use the process suggested here. However, local statutes may direct the use of alternate procedures.

5. Orientation

The purpose of orientation is to provide the new board member with information which will familiarize him/her with the center's operations and help speed integration into the center's structure. There are a number of activities which can be included in the orientation program:

Training session(s)—films, lectures, visits, etc.

Meeting with the executive director and other staff members

Visiting center facilities and observing operations

Meeting with board officers

Serving as a volunteer in several different components of the center's program

An orientation kit should be prepared for each new member. It is often advisable to hand out appropriate portions of the kit during each of the activities scheduled during the orientation period. The complete kit should contain at least:

The center's constitution and bylaws

A brief history of the center and a statement of its philosophy and objectives

Organizational charts of the governance, administrative, and service structure

Board rosters and committee assignments

Staff rosters and assignments

Recent annual report(s)

Current budget and last audit report

A statement defining board responsibilities and a schedule of board meetings for the coming year

Catchment area demographic profile and recent needs assessment report
Outline of the center's program and activities
Recent board minutes
Recent evaluations or special reports
Description of relationships with other agencies
Center publications, newsletters, etc.
A statement on confidentiality
Insurance and liability information

While the items listed above are of proven worth, nothing is more vital to the orientation process than responding to the questions of the new board member. Issues involved in board development and training will be discussed in chapter V.

6. Recognition

Recognition should not be reserved for the final meeting which a retiring member attends. Throughout his/her tenure of service, a board member's productivity will be influenced in part by the extent to which that person's needs are being met. While there is significant satisfaction which results from providing service, each of us has a need for recognition. The board experience should not only include meaningful opportunities and challenges, but acknowledgement of service and special effort as well. Recognition of board members for conscientious service rendered should follow each evaluation by the board of its own operations. Clearly outstanding contributions by board members should be documented, honored, and disseminated for recognition in the community as an effort to generate more support and participation.

7. Termination of Services

The termination of an individual board member's service to a center may be voluntary or involuntary. Voluntary termination takes place when an individual resigns or completes his term of office and is ineligible for reappointment. Involuntary termination takes place when an individual is asked to resign. It is the responsibility of the board membership committee to see to it that the termination and transition are handled as smoothly as possible. The thing to be remembered, when board members terminate, is that they return to the community and can be a source of continuing help or a cell of citizen resistance and a barrier to the future development of the CMHC.

ORGANIZING THE BOARD

Consistent with the principle that structure is to serve function, committees should be organized around the board's major objectives. They should be authorized in the bylaws. There are generally four types of committees:

1. The Executive Committee is composed of board officers, committee chairpersons, and a few members at large. It serves as an overall planner and monitor of committee and board functioning. In addition, it is usually authorized to deal with situations requiring board action which occur between board meetings. This committee plans and oversees the board's self-evaluation process. It also oversees the operation of the budget of the board itself.
2. Standing Committees, generally defined in the bylaws, are permanent committees which are constituted in accordance with the center's primary objectives. Usually recommended committees are: board membership, administration or management, program, personnel, finance, community relations, and public relations. Responsibilities assigned to these committees are as follows:

   Board Membership Committee—all issues related to board-building subprocesses such as membership needs assessment, identification of prospective board members, selection of candidates, recruitment and appointment of new members, orientation, inservice training, recognition, and termination of service
   Administrative or management committee—issues related to policy development, legal status issues, accountability to governmental agencies and the public, legislative issues, physical plant development, and maintenance

Program committee—all issues related to the assessment of community needs for service, development of new programs of service, and services monitoring and evaluation

Personnel committee—all policy issues related to staff recruitment and development; salary and benefit programs; promotion, grievance, and termination procedures; staff organization and evaluation; labor/management relations; job descriptions; and volunteer recruitment and training.

Finance Committee—all issues related to fiscal planning, both long and short range; budget formulation and recommendation; fiscal controls; audit; investments; fund raising; fees; and grant solicitation. This committee works closely with the executive director but reports to the board.

Community relations committee—all issues related to developing and maintaining relationships with formal and informal community organizations so as to facilitate development of a comprehensive network of services for all residents of the catchment area.

Public relations—all issues related to informing the community of the center's programs and services through annual reports, special events, etc. It includes media relations. Close coordination and contact should be maintained with the consultation and education program component.

3. Subcommittees, established by a committee chairperson, are delegated responsibilities for specific tasks within the work of a standing committee including reporting to their parent committee.

4. Special Committees, established by the board and appointed by the chairperson of the board, are temporary committees responsible for fulfilling a specific and time-limited need. They report to the board.

EFFECTIVE COMMITTEE CHARACTERISTICS

Each committee has a unique pattern for meeting its responsibilities, and much research has been done on small group productivity and effectiveness. Rensis Likert, one of the foremost developers of the human relations approach to management, has defined 24 properties and performance characteristics of the ideal highly effective group. The following list is recommended as a basis for establishing criteria by which the committees may be judged:

- The members are skilled in all the various leadership and membership roles and functions required for interaction between leaders and members and between members and other members.
- The group has been in existence sufficiently long enough to have developed a well-established, relaxed working relationship among all its members.
- The members of the group are attracted to it and are loyal to its members, including the leader.
- The members and leaders have a high degree of confidence and trust in each other.
- The values and goals of the group are a satisfactory integration and expression of the relevant values and needs of its members. They have helped develop these values and goals and are satisfied with them.
- Insofar as members of the group are performing linking functions, they endeavor to have the values and goals of the groups which they link in harmony, one with the other.
- The more important a value seems to the group, the greater the likelihood that the individual member will accept it.
- The members of the group are highly motivated to abide by the major values and to achieve the important goals of the group.
- All the interaction, problemsolving, decisionmaking activities of the group

occur in a supportive atmosphere. Respect is shown for the point of view of others both in the way contributions are made and in the way they are received.

- The chairperson of each work group exerts a major influence in establishing the tone and atmosphere of that work group by his leadership principles and practices.
- The group is eager to help each member develop to his/her full potential. It sees, for example, that relevant technical knowledge and training in interpersonal and group skills are made available to each member.
- Each member accepts willingly and without resentment the goals and expectations that the group establishes for itself.
- The leader and the members believe that each group member can accomplish "the impossible." These expectations stretch each member to the maximum and accelerate individual growth.
- When necessary or advisable, other members of the group will give a member the help he/she needs to accomplish successfully the goals set for him/her. Mutual help is a characteristic of highly effective groups.
- The supportive atmosphere of the highly effective group stimulates creativity.
- The group knows the value of constructive conformity and knows when to use it and for what purposes. Although it does not permit conformity to affect adversely the creative efforts of its members, it does expect conformity on mechanical and administrative matters to save the time of members and to facilitate the group's activities.
- There is strong motivation on the part of each member to communicate fully and frankly to the group all the information which is relevant and of value to the group's activity.
- There is high motivation in the group to use the communication process so that it best serves the interests and goals of the group.
- Just as there is high motivation to communicate, there is correspondingly strong motivation to receive communications.
- In the highly effective group, there are strong motivations to try to influence other members as well as to be receptive to influence them. This applies to all the group's activities: technical matters, methods, organization problems, interpersonal relationships, and group processes.
- The group processes of the highly effective group enable the members to exert more influence on the leader and to communicate far more information to him/her including suggestions as to what needs to be done, and how he/she could do his/her job better, than is possible in a one-to-one relationship.
- The ability of the members of a group to influence each other contributes to the flexibility and adaptability of the group.
- In the highly effective group, individual members feel secure in making decisions which seem appropriate to them because the goals and philosophy of operation are clearly understood by each member and provide him/her with a solid base for his decisions.
- The leader (chairperson) of a highly effective group is selected carefully.

A WELL-ORGANIZED BOARD

The board is a merger of positions, people, and their associated tasks. If the board building and organizing processes have been successful, the board's composition will reflect the diversity of the community it serves, and thus, capable individuals will be available to meet the special needs of the various committees and the center as a whole.

The characteristics of a well-organized board structure may be summarized as follows:

The committee network is no more extensive than is required and is reviewed regularly.

Board members have committee assignments related to their interests and skills. There is an open, adequate, and orderly flow of communications between

the committees, the board, and the executive director.

Responsibility and accountability relationships among elements of the board structure are clear.

There is a high degree of coordination in the center's activities.

BOARD OPERATIONS

Governing-advisory boards need to develop specific plans for their operations for each fiscal or program year. Those plans should include the specific objectives they want to achieve within the span of the year. The plan should also identify the resources that will be needed by the board itself to operate during the year. Included in the resource estimates should be the staff help required, the reimbursement money required, the funds for any consultant or training assistance required, and sufficient money to cover the costs of projected meetings outside the center. Included among the resource estimates should be travel costs of the board on official business for the center.

Other means can be employed to insure regular attendance of members, such as "buddy" system for new members or holding some noon meetings which probably will be shorter than night meetings, and making sure members have an opportunity for satisfying participation. An example of the latter would be to arrange assignments to insure that an individual can use his/her own skills and capabilities and feel that his/her personal goals and ideologies are recognized, or that each member is challenged to address important problems. Members must feel that they have some control and that being on the board will lead to making important decisions which produce positive results. This approach is almost certain to insure consistent dedicated participation by most board members.

Chapter IV

Board Development and Training

This chapter focuses on the issues of board development and training. It accepts the challenge of improving the operations of the governing/advisory board itself. It explores ways of meeting that challenge and the reasons for doing it. More specifically, it presents particular ways of assuring that members of the governing/advisory boards acquire the knowledge and skills they need to do their jobs.

In chapter II of this manual, the roles, responsibilities, functions, and authorities of the governing/advisory board are listed and explained. The critical questions which arise are: How can boards make certain that both old and new members get an understanding of their tasks? Further, how can boards assure improvement in the performance of individual members?

REASONS FOR BOARD TRAINING

There are at least four reasons for a CMHC to create and maintain a board development and training program.

- The first is to make certain that board members have the opportunity to secure the knowledge and develop the skills to be effective in performing their tasks and functions.
- The second is to give them a common vocabulary of the language and concepts essential to communicating in the CMHC system.
- The third is to keep members up to date on regulations, policies, and programs.
- The fourth is to reinforce the idea of the board as a team rather than a group of unrelated individuals.

ORIENTATION OF NEW MEMBERS

There is general agreement that new members of governing/advisory boards should receive careful, organized orientation for the roles they are to play. This means that the CMHC's existing governance program must include a commitment to and a plan for such orientation. If an orientation program is not in place, the current governing/advisory board will need to see to the creation of such a program. The executive director of the CMHC must be able to provide the staff assistance needed to develop the plan and to make it work. The resources necessary for such a program should be built into the management and governance costs of the center budget. If not, special arrangements should be made to insure their inclusion in the budget for future years.

Orientation of new board members must be viewed as an integral part of the programing of the CMHC.

OLD MEMBERS

Experience reveals that even old members of governing/advisory boards have varied understanding about their roles, responsibilities, functions, and authority. The smooth, effective functioning of the governing/advisory board of a CMHC requires that there be, at a minimum, some common base of information and understanding shared by all members. Therefore, it may be necessary to create programs for old board members designed to reorient and update them. Programs designed for old board members will be different and should be separate

from those tailored to orient new members. For example, old members should not be required to go over policy and program information to which they have been exposed before, except as a refresher. The executive director of the CMHC should be able to provide essential staff assistance in the design and carrying out of such programs. Where programing has not been planned and included in the budget, special arrangements can be made for the current year, while planning takes place for the future.

In the board's plan for its operation, a specific section should be devoted to board development and training. That section should point out the development and training objectives for the year and specific plans for achieving them, including the resources required.

For example, CMHC *X* includes the following in its governance plan: CMHC *X* will seek to improve the operation of its governing board in order to assure greater citizen participation and center responsiveness. As specific objectives, the center commits itself to:

1. Train its governing board in the techniques of citizen involvement in the CMHC by the end of the first quarter of the fiscal year.
2. Complete the preparation of a board policy and procedures manual by the end of the 2d quarter of the fiscal year.
3. Develop a program for orienting new board members by the end of the 3d quarter of the fiscal year.
4. Revise the operating budget to include the resources necessary for achieving objectives 1, 2, and 3 above, by the end of the third quarter (estimated cost $15,000).

The example refers to training board members for assuring citizen participation and center responsiveness. Actually, centers should develop comprehensive inservice training and development programs which help individual board members increase their knowledge and skill in a variety of areas. The program should include training in communication skills, leadership skills, policy decisionmaking skills, fiscal management skills, community representational skills, legal and advocacy skills. The community representational skill includes knowing what the community needs and sharing that knowledge as appropriate in the governance processes of the board. It also includes knowing what the center needs and sharing those needs with the community as appropriate opportunity permits. These are the skills which involve two-way interpretation on the part of board members. They are the skills through which the board member plays out the political role inherent in the job of board member.

Certain knowledge and skills are necessary to the functioning of the board as a group when it makes policy decisions. The use of *Roberts' Rules of Order* (parliamentary procedures for handling meetings) is an example. In most centers, these serve as the guidelines for conducting the business meetings of the board. Those board members who learn the rules and become confident and skillful in their use tend to emerge as the influential people in the board operation. Those members who do not learn the rules and do not develop skills in the use of *Roberts' Rules of Order* tend to have difficulty representing their constituency effectively in the decisionmaking process.

Board development and training in budgeting and other aspects of fiscal management are essential. Sound fiscal policymaking requires that board members acquire some understanding of what a budget is and how it relates to services. Fiscal policy is based on a point of view about money, its use and misuse.

Most persons elected to the board have had their own personal experience in handling money. However, the board member needs to approach the management of the center's money as a public trust. Decisions should be based on sound fiscal information and professional judgements. An inservice training program should provide the common knowledge base necessary to board participation and decisionmaking.

BOARD AND STAFF TRAINING

The experience of CMHCs to date reveals the existence of a normal kind of tension between the citizen governing boards and the professional staff, represented by the

executive director and other management personnel. That tension can be creative and positive, or it can be permitted to become negative and destructive. Governing/advisory board members have significant responsibility for what develops in this set of relationships. One way to develop cooperative working relations is through a shared training experience. The decision whether to train board and staff together will depend on who is to be trained and what their training requirements, goals, and objectives are.

The District Boards Training Program of the Florida State Association of District Mental Health Boards is an example of a training program that emphasizes organization, development, and management skills of board members and administrative staff of governing boards in Florida. The purpose of the program is to help participants function more effectively, build and maintain a healthy organizational structure, and strengthen their capacity for coping with changes in the system. The program staff identifies the board's organizational needs and designs and conducts appropriate training activities.

The format most often used is that of experience-based workshops in which participants "learn by doing" through active involvement. Workshops are typically 1½ days long. Prior to the workshop, participants select three of nine learning modules on the subjects of communication, organization, and managing change.

The program assumes that training board and administrative staff together results in a better understanding of mutual goals and facilitates communication. It includes office personnel (secretarial and clerical) in the training, since they are the key individuals in the organization's communication network.

In this program, board training is viewed from at least two dimensions: (1) organization development or management training, and (2) informational training or technical assistance. It suggests that it is possible to determine the most appropriate type of training by asking the following questions:

Why do we need training?
What do we want to accomplish?
What kinds of learning will occur?
Who can best provide this training?
When and how can the training be provided most effectively?
What is the most appropriate method for presenting this training?
How will we finance the training?

If the goal is to increase organizational effectiveness, consultants with organization development and management skills design an ongoing learning process that includes the participants in the planning and utilizes various types of training events. If the goal is to provide information, specialists with specific knowledge present the information, usually by means of a lecture, wirtten materials, and/or technical assistance.

Funds for training may be available through associations, as in Florida, or through private grants. However, funds for training are earmarked in the 2 percent Technical Assistance money provided for under P.L. 94-63, Title III, Section 206/ Subsection 6e. Such funding may be secured through the Regional Offices of the Alcohol, Drub Abuse, and Mental Health Administration of the Federal Government.

TRAINING AND EVALUATION

Boards should have evaluation training at two levels. The first has to do with evaluation of the total center operations including its services. The second has to do with its own operations as a board (self-appraisal).

Training for appropriate role performance at each of these levels should be separate parts of a complete board training and development program. The probabilities are that special training will have to be carried out each year in preparation for the annual evaluation, at each of the levels. The training can be relatively simple, if the center evaluation design and the board self-appraisal design have been approved earlier by the board, and if the records and reports of the center and board operations have been maintained according to plan. Evaluation activities are discussed more fully in chapter VI.

TRAINING FOR ACCOUNTABILITY

According to the book, *Citizen Evaluation of Mental Health Services:*

> Accountability, as a general term, means that a person is responsibile to someone else for accomplishing certain results with the resources available to him. In the mental health field, program accountability refers to the responsibility of the agency or program staff to produce certain kinds of results with the funds and other resources allocated to it.

Board members carry a responsibility for the CMHC operation and its future. They are held accountable for what they do in the interest of the community and for the performance of the CMHC. Special effort must be put forth to make certain that board members understand and accept their own accountability, as well as that of the center staff.

Training for accountability must recognize to whom the board is accountable as well as for what. The issues of Federal, State, and local accountability, legal accountability, and catchment area accountability are involved. The training must also assure that board members have the knowledge and skills essential to their roles in service audit reviews and fiscal audit reviews. The audits, both program and fiscal, deal with the procedures and the results of program and fiscal operations at a particular time. They are usually carried out by trained professionals. The reviews deal with the audit reports themselves and are carried out by the board with the participation of the executive director.

The particular kind and design of training will vary depending on who is to be trained, what the training objectives are, what the content of the training is to be, and who will do the training. The governing/advisory board working with the executive director will want to face and answer these questions clearly before settling on a particular training program for the CMHC board.

TOOLS FOR TRAINING

Governing/advisory boards have available to them a variety of tools and resources for training:

1. The specialized standing committees of the board become knowledgeable in-depth in particular areas of center operations, e.g., finance committee, public relations committee, service committee. Their expertise should be used.
2. Professional advisory boards represent a body of available professional knowledge and skills which can and should be used.
3. The key staff members of the center usually are expert in service areas of operation, both administrative and clerical. They should be sought as resources through the executive director.
4. The other mental health organizations in the municipality, county, or State may be explored and considered as potential resources.
5. Public organizations, private organizations, and associations at the local, State, and national level, both profit and nonprofit in character, offer training and technical assistance services. Many of these are listed in Appendix B.
6. At each level of general purpose government, national, regional, State, and local, the mental health agency may have a training or technical assistance capability. Where either exists, training help may be found.

Chapter V

Professional Advisory Boards

It is clear that one of the most important functions of the governing board is to establish the center's policies. In carrying out its responsibilities in this area, especially with regard to medical and other service delivery issues, the governing board has a valuable resource in the professional advisory board (PAB) Congress assured such input by requiring [Section 201 (d), Public Law 94-63] the establishment of a professional advisory board, to advise the governing board in establishing policies governing medical and other services provided on behalf of the center.

PROFESSIONAL ADVISORY BOARD AND GOVERNING BOARD RELATIONSHIP

There is no formula for determining the "right" relationship between the professional advisory board and the governing board. The professional advisory board should relate directly by means of nonvoting representation at governing board and committee meetings, or directly by transmitting its input in writing through the executive director. Regardless of the structure adopted in a given center, it is essential that the autonomy and integrity of the professional advisory board be preserved. The professional advisory board should never become a political tool or "rubber stamp" for either the executive director or the governing board.

On the other hand, it is not at all unusual or unexpected for professional advisory boards to have a great deal of policy influence. Though their recommendations are not binding, their input carries the authority of expert knowledge.

Governing boards must, therefore, be alert to the danger of being influenced too much by such expertise. While respecting professional opinion, the governing board must afford equal respect to the expertise of nonprofessional citizen board members. In areas such as needs assessment, for example, the knowledge and understanding of the community possessed by lay governing board members may be of more value than professional expertise.

Carefully considered assignments of responsibilities and respect for the resources which each group brings to the center will assure a balance between professional and lay influence. Each group can and should function in a manner which encourages and enhances the effectiveness of the other.

COMPOSITION OF THE PROFESSIONAL ADVISORY BOARD

The professional advisory board is typically composed of the heads of the various federally mandated service units of the CMHC. Other key administrative or clinical staff members may be included.

In general, it is not advisable for the executive director to serve as a member of the professional advisory board, even as an ex officio member. At the same time, his input in the form of reports or recommendations may often be requested by the board.

While the legislation indicates that the professional advisory board should be composed of members of the center's professional staff, the participation of outside professionals is not precluded. The only issue of concern in this regard is possible conflict of interest. Under no circumstances should a member of the professional advisory board be employed by the center as a paid consultant. Otherwise, the inclusion of outside pro-

fessionals with particular expertise may contribute importantly to expanding the professional perspective.

ROLE OF THE PROFESSIONAL ADVISORY BOARD

The main role of the professional advisory board is to advise the governing board on matters of policy, particularly those which involve services and service delivery.

It is common for the professional staff through its day-to-day contact with clients to be first to recognize service issues for governing board policy consideration. In reviewing such matters, the professional advisory board will recognize the need to consider changing current policies or will anticipate the need for establishing new policy.

At the same time, members of the governing board may discover that policy does not exist to justify a particular procedure or method of operation. Under such circumstances, the accountability role of the board may dictate the need for establishing new policy. The importance of this point is to be found in the common circumstances where a particular medical procedure is in effect over a period of time and goes unquestioned because it has always been done this way. While such time-tested procedures may ultimately prove to be effective and adequate, it is the responsibility of the governing board to provide justification for center procedures more valid than tradition. In such a situation, a review by the professional advisory board is desirable.

Regardless of how the identification of policy issues occurs, the professional advisory board should be requested to prepare a policy statement which includes:

a. *Definition of the Parameters of the Issue:* This section should include an analysis of the nature, extent, and distribution of the issue. What is the nature of the issue? How many clients are being affected by the procedure in question? How many staff hours are being invested in the program? What is the theoretical base which dictates the procedure currently in effect?

b. *Substantiation (or Denial) of the Need for New Policy:* What will be the effect of not adopting the policy? Will the establishment of explicit policy reduce needed flexibility? Or, will it provide opportunity for the development of more effective procedures? Will the achievement of the center's objectives be enhanced or hampered by adoption of new policy?

c. *Assessment of Existing Policies:* Are there currently existing policies in other areas which may impinge on this issue? If so, can options be identified which will not create internal contradictions? If not, can policy options be identified which will not have a negative impact on other issues?

d. *Identification of Policy Options:* What are the policy alternatives? How will each serve to meet the client's needs? What unintended effects may result from each? What are the overall costs and benefits of each? How does each compare with the implicit policy already in existence?

e. *Preferred Policy Alternative:* Does the professional advisory board recommend a particular policy? Why?

OTHER RESPONSIBILITIES OF THE PAB

Policy advising is the primary responsibility of the professional advisory board. In some centers, secondary responsibilities such as the following have been assumed:

a. Professional advisory boards may serve as internal peer review and utilization review bodies.

b. Professional advisory boards may serve as a resource for the governing board training programs. Two content areas suggest themselves for this function: translation of legislation requirements, regulations, and standards established by outside agencies; and evaluation of various treatment modalities. Other topics would certainly suggest themselves as such a process evolves. Other examples might include research and patient complaints.

Chapter VI

Evaluation

This chapter provides essential information about the evaluation of CMHC operations. It is designed with the particular requirements of citizen governing/advisory boards in view. However, its focus is on accountability to the community and at the catchment area, State, regional, and Federal levels.

In his foreword to the guidebook entitled, *Citizen Evaluation of Mental Health Services,* Dr. Bertram S. Brown, former Director of NIMH, said,

> Effective citizen participation requires an understanding of the nature of mental health problems and of the various types of services needed and available. A citizen role in evaluating public (mental health) service programs can both educate citizens and be a source of helpful information to guide providers of care to improve their services.

Those statements have special relevance for citizens who assume the roles of governing/advisory board members. They suggest the central nature of the commitment each member must make not only to understanding the CMHC to which he/she is affiliated, but also to the issue of accountability for every aspect of the operations of the center. Further, they suggest the requirement to learn the scope and nature of evaluation programs and tools well enough to enable participation in the decisionmaking process as may be appropriate in planning for evaluation, and utilization of the evaluation, of programs for policy changes.

To further those developments, the following items are discussed in this chapter: an operating definition of evaluation; description of various evaluation techniques; information about how some evaluation techniques are performed and by whom; suggestions as to the use of evaluation results; identification of organizations prescribing standards for CMHCs and comments about training.

WHAT IS EVALUATION?

Evaluation in a CMHC is the systematic process of determining whether and to what extent planned objectives have been achieved. Its primary purpose is the development of information which is essential for decisionmaking about the future of the CMHC; its policies; its services; its organization; its relationships to Federal, regional, State, and local government, and to other providers and consumers.

Citizen concerns about rising costs and the effectiveness of mental health care have resulted in increasing pressure for evaluation and accountability. Legislators at all levels, taxpayers, and consumer advocacy groups, through their demands for accountability, have made it clear that evaluation programs can no longer be listed in the category of something which may or may not get accomplished. Where CMHCs are concerned, meaningful evaluation must increasingly become a permanent and prominent item on the current agenda of all units within the CMHC operation and for related service providers as well. This responsibility ultimately resides with the citizen governing/advisory boards. The responsibility must be discharged in the normal course of their work and should be carried out in close collaboration with the executive director and staff of the center and residents of the catchment area.

In the past, centers have frequently left the bulk of the responsibility for evaluation to external agencies within the network. It was often felt that feedback from the periodic monitoring by NIMH or from site visits by other accrediting agencies would

provide sufficient evaluative input for policy-level decisionmaking purposes. Both NIMH and Congress recognized the deficiencies in such an approach. Therefore, Congress mandated in Public Law 94-63 that every center receiving a grant must use an amount equal to at least 2 percent of its previous fiscal year operating expenses for evaluation of its services. This mandate further demands that CMHCs develop programs which enable citizens and their organizations to know what, how, and why certain situations exist at their center.

EVALUATING OPERATIONS

It is important that board members and staff take an active role in the evaluation of the CMHC. The board and the staff must develop full acceptance of the evaluation process. They enlist the frank support of consumers and citizen volunteers. They can stimulate confidence in the evaluation. Sometimes evaluations may be best conducted by an outside group of professionals. At other times the board and staff may conduct them with outside professionals serving as technical consultants. In either case, the clear and active participation of board and staff members is a must.

The following process steps are modifications of suggestions by Dr. Gordon Lippit, a behavioral scientist, as ways of avoiding pitfalls in evaluations:

(1) One person needs to be selected to coordinate the evaluation effort. This person may be on the board or a person in the community who is requested by board and staff to be evaluation coordinator. It might be the chairman of the planning and evaluation committee or a member of the staff.

(2) An ad hoc evaluation committee should be appointed if one is not already in existence. This gives credibility, acceptance, and importance to the evaluation process.

(3) Everyone should be informed about the evaluation plan. All board, staff, agencies, and community groups should be informed. Evaluation should not be a mysterious process which threatens group, individuals, or organizations.

(4) The objectives of the evaluation plan should be clearly stated and understood.

(5) Data collection instruments should be kept simple so that people can respond clearly and understand what is asked.

(6) People should have enough time to respond so that they do not feel harassed by the evaluation process expectations.

(7) The evaluation process should be as natural as possible. It should be seen as a regular part of good management, planning, and programing.

(8) Only data that are needed and can be used should be collected.

(9) The evaluator should be alert to possible areas that may have been left out of the data collection plan.

(10) There should be attention to the way in which things happen as well as statistical data.

(11) The instruments for evaluation should be well prepared so that they do not slant, prejudice, or distort the responses.

(12) The evaluator should be open and responsive to respondents' needs and interests. Evaluation is not a police action. It is a confidential, collaborative effort toward better community mental health.

(13) Being an evaluator is much more than looking for the negative. Evaluation should be seen as a step toward improvement.

(14) Evaluation plans should build in a feedback process. The providers of information get back reports and information that will help and support their efforts.

(15) If possible, there should be an outside resource consultant/expert to review the evaluation plan before data collection.

(16) Be ready to accept the consequences of the evaluation process. It may create anxiety among staff, board, and agencies.

(17) In doing evaluation, be business-like. People should feel that this evaluation process is well done and that the evaluators know what they are doing.

(18) Make sure that the ground rules are clear and understood on who has access to the evaluation data:
(19) Remember to thank the givers of data for their cooperation and collaboration. They have given you their time and effort.
(20) Remember that evaluation is not an end in itself. It is a means to improve CMHC planning and operations.

If boards do their own evaluations, they should assure that there is adequate documentation for their evaluation so as to reveal any subjective content. Site visits are particularly important as a tool for evaluation, because the oral interchange with professional evaluators, on the spot, is sometimes more valuable than written answers to questionnaires and reports.

Boards should have an awareness of all the reports required of the executive director. They should examine these to the extent necessary to understand what has happened—the study of services, the number and types of clients, affirmative action, etc. Statistics can be compared between months and years to see if the agency is meeting its overall objectives. One center in the Midwest requires quarterly reports on all services.

The annual financial audit that is required should be carried out by an impartial, outside certified public accountant. There is also need to audit programs where activities are reviewed and analyzed in terms of whether objectives have been met. As an example, one center prepares an annual report. Its program auditor tests its goals and objectives against the product or service actually delivered and renders an opinion.

THE CONTINUING NATURE OF EVALUATION

Considerable emphasis should be placed on the continuing nature of an evaluation program. It should not be merely an annual event, but it should be a continuous process, probably handled by a subcommittee of the board working with the executive director. To facilitate this approach, a number of centers have their boards set three priorities for the entire year, with a detailed schedule of objectives and the proposed outcomes. The priorities are reviewed at 6-month intervals. Another center has a staff system, including a staff ombudsman who speaks directly to the clients. Still another center has staff conduct individual interviews with clients who did not keep their appointments, thus revealing aspects of the center's operations which need improvement, such as promptness of service, hours of operation, and the location of service centers.

External health planning agencies which have an impact on individual center programs, such as Health Systems Agencies, State hospital systems, and State mental health authorities, need to be contacted so that their efforts can be coordinated with those of the board. The Mental Health Association has a comprehensive evaluation package which could be used by boards in evaluating CMHC operations.

CATEGORIES OF EVALUATION

There are several ways of identifying and listing essential categories of evaluation in a CMHC. For the purpose of this manual, the following are used:

1. Community needs assessment
2. Monitoring, including Management Information System (MIS)
3. Services evaluation, including personnel assessment
4. Board self-appraisal

Taken together, these may be viewed as a comprehensive evaluation package.

COMMUNITY NEEDS ASSESSMENT

One of the inputs which the environment provides is information about the requirements the community has for service. A plan which seeks and sorts out particular kinds of information from the environment is called a Needs Assessment. Its purpose is to ensure that the prevalent, pressing, and potential needs of the catchment area are identified in their priority order for receiving attention. These data are the base for planning services as well as for evaluation. A needs assessment program requires the identification of both the community's characteristics and the problems of its people. It

should also include the description of trends and future requirements. Some of the categories of information required in the development of such as assessment are listed below:

Current Community Characteristics:

1. *Population:* size, sex ratio, age distribution, density, racial and ethnic compositions, and cultural information
2. *Socioeconomic Status:* income distribution, employment level, education level
3. *Household Composition and Family Structure:* household size, single-parent families, working mothers, aged person living alone, persons not in families, teenagers not in school
4. *Housing:* density, type, condition

Current Community Problems:

1. *Family Disorganization:* Divorces, desertion, nonsupport, child abuse
2. *Substance Abuse:* Drug and alcohol abuse, admissions to mental health programs, drug and alcohol related arrests
3. *Crime and Delinquency:* Crime rate by categories, commitments to youth facilities, cases of reported assaults and violences
4. *Schools:* Number of dropouts, number in classes for emotionally disturbed, suspensions, expulsions, etc.
5. *Mental Health Facilities:* Number of inpatient cases, number of outpatient cases

Adequate assessment of community needs demands full participation of citizens. It must not be left to the professional staff of the CMHC. Valid judgments about the community's characteristics and its problems require both the perspectives of the professional staff and of the citizen resident. For example: NIMH has developed a Mental Health Demographic Profile System which tabulates information about the social and economic characteristics for each community mental health service area in the United States. These data can be used to assess conditions frequently related to mental health. However, the assessment requires the perspective of the citizen to offset the inherent limitations of the data and the bias of the professional.

Information about community problems which may or may not have particular mental health implications can be secured from State and county mental health departments, from local schools, churches and police departments, or from planning agencies at the local, county, or State level. However, there is no substitute for seeking information from the community through a representative sampling of its residents. Such a survey effort can be undertaken as a team effort made up of citizens, CMHC staff, and other providers.

The assessment of need in the community and judgments about their priority are critical. It is, therefore, clearly urgent that governing/advisory boards participate and maintain an active interest in this type of evaluation. Through this effort, citizens will have a reasonable guarantee that what the residents of the catchment area see as their greatest mental health needs will be given greatest priority in programing for the CMHC.

MONITORING

Monitoring in the CMHC operations is generally considered a part of a total evaluation program. Monitoring is the activity which enables the managers of the CMHC to keep track of what is happening on an hour-by-hour, day-by-day basis. This activity provides the kind of information that makes it possible for those in charge to identify problems promptly and make corrections or adjustments, where necessary. It should be possible for the governing/advisory boards to check on how things are operating at the center at regular board meetings.

THE MIS

The primary tool used to collect, store, and *feed back* current information about operations is the Management Information System (MIS). Such systems may be manual; that is, the records, files, and reports are prepared and submitted by hand. They may be automated, with the information being recorded, stored, processed, and fed back electronically by computer. In both situations, the most important issues are:

1. The information collected routinely must be facts about the operations that

management including citizen and governing/advisory boards *need to know.*

2. The system must be designed so that information about the current operation can be compared to the plans for the operation at the same time. Thus, the board and staff can know whether or not operations are on schedule and producing services as planned. If the objectives of the center include time tables and if the plans have milestones, then tracking is made easier.
3. The system must have a way of highlighting things which are exceptions to the operation plan. These exceptions, when caught and resolved soon enough, may prevent further serious problems like overexpenditure and improper services becoming built in.

The computerized MIS is a responsive tool in the total evaluation program when used appropriately. Its primary value focuses on its ability to receive, process, store, and transmit large masses of information easily and quickly. Thus it can become the repository of all of the basic data needed for evaluation and decisionmaking at the several points evaluation should occur, e.g., quarterly or annually. The decision to remain manual or go electronic with the MIS should be carefully considered after evaluating the use of the MIS, its cost, and its impact. Boards may wish to secure technical assistance in developing and installing an automated MIS.

SERVICE EVALUATION

Under Public Law 94-63, CMHCs are called upon to evaluate their services in at least the following categories:

1. Costs of service
2. Patterns of use of services
3. Availability, accountability, and acceptability of services
4. Impact of services

Governing/advisory boards, as representatives of the residents of the catchment area, should give particular attention to making certain that service evaluation is planned and carried out with the executive director or his designee. This particular type of evaluation provides information, analyses, and conclusions about the center's service operations. Based on the review made by governing/advisory boards of the analyses and conclusions contained in the categories listed previously, specific recommendations for change and improvement can be made.

> For example, assume the CMHC needs assessment shows a large population of elderly needing help. Assume the CMHC approved plan of operation makes available significant resources for service to the elderly. Assume also that the evaluation of service reveals that the elderly are not using the services of the CMHC, but that middle-aged women are using services far beyond the volume anticipated and planned. Clearly the governing/advisory board has an obligation to find out why the elderly are not using the center, why the middle-aged women are using services in such volume, and to provide for modifications which are warranted following an analysis.

In the above example, the governing/advisory board is interested in several things. First, it is concerned that the community population designated as needing services most was not getting it; second, it is concerned that the CMHC is apparently not operating as planned; and third, it is concerned that resources are being used in ways contrary to the board decisions. All of these concerns are legitimate accountability issues for governing/advisory boards.

It should be noted that service evaluation either directly or indirectly involves the evaluation of personnel of the center who manage and deliver services. Such evaluation includes assessment of external service providers who are a part of the CMHC program and are accountable to the center. In each instance, the service delivered, its nature, its quality, and its results should be looked at closely by the board. Professional Standards Review Organization (PSRO) activities will be useful in this connnection.

In the evaluation of services, the standards established and monitored by certain organizations have special meaning. Among the organizations acknowledged to have input into the development of service standards are the NIMH, JCAH, MHA, State and local mental health authorities, and the PSRO (see Appendix B).

BOARD SELF-APPRAISAL

Evaluation by the governing/advisory board of its operation is a very important part of the total program. There are three

critical questions which require answers in such assessments:

1. Did the board have a plan for its operations which included particular goals and objectives? What is the evidence? Were training and board development included?
2. Did the board achieve its objectives and move closer to achieving its goals? What is the evidence? Is it more efficient? Does it relate better to staff? Does it represent the catchment area more effectively?
3. Did the board develop plans for the next operating period (fiscal year) which was based on its deliberate assessment of the experience of the past operating period? What is the evidence? Did it use the needs assessment as a base? Did it focus on results as well as process?

Governing/advisory boards have an accountability relationship to the catchment area which demands such self-assessment. In fact, it is that "community accountability" which dictates the content of the board's self-assessment. For example:

1. Did the board's plan for its operation include guidance and participation in a community needs assessment?
2. How did the board give guidance and participate in the community needs assessment if at all?
3. Did the board project new and modified plans for participation in future community needs assessments based on its evaluation of its own experience?

The governing/advisory board must be concerned that it understands and delivers on its responsibility and commitment to citizen participation. The self-assessment process provides one mechanism for making a careful judgment. Bits of evidence of the board's performance may also emerge from other elements of the total evaluation program. In any event, assessment of the board's operation is essential to full and complete evaluation of the CMHC, both internally to the staff and board of the center and externally to the community and various public agencies.

PREPARATION FOR EVALUATION

Like most professional and paraprofessional providers, members of the governing/advisory board need to be prepared to participate appropriately in the CMHC evaluation program. The tools and techniques of evaluation are varied and range from the simple to the very complex. Several specific studies have been undertaken on behalf of NIMH that develop and present, in book or manual form, information about those techniques which are presently useful.

The three which seem noteworthy are:

1. *A Working Manual for Simple Program Evaluation Techniques for Community Mental Health Centers,* prepared by Arthur D. Little Co.

2. *Citizen Evaluation of Mental Health Services,* a guide book for accountability. This book is the product of the Tufts University Citizen Evaluation Research Project prepared by Val D. MacMurrary, Perry H. Cummingham, Phylis B. Carter, Norma Swenson, and Seymour S. Bellin.

3. *Resource Materials for Community Mental Health Program Evaluation,* published by NIMH and edited by William A. Hargreaves and C. Clifford Attkinson of the University of California and by James E. Sorenson, University of Denver.

CMHC governing/advisory board members will want to review the several evaluation approaches currently in use. After a period of experience, with some assessment of that experience, an approach may evolve which best meets the needs of a particular center. However, the mistake of choosing one approach for all time should be avoided. Even the evaluation approach should remain subject to change and improvement.

Under P.L. 94-63, the CMHC is required to provide some vehicle for citizen review of the program of services and other operating information. Such a citizen review should be based substantially on the annual evaluation results of the CMHC.

Appendix A

Glossary

CLINICAL TERMS

Mental health. A relatively enduring state of being in which an individual is reasonably satisfying to self as reflected in his/her zest for living and feeling of self-realization. It also implies a large degree of adjustment to the social environment as indicated by the satisfaction derived from interpersonal relationships as well as achievements.

Mental illness. A state of being in which an individual has difficulty in handling situations and feelings of an everyday nature. It usually includes anxiety and concern out of reasonable proportion, accompanied by a feeling that problems are becoming too much to handle. Often, symptoms are those of feeling constantly bad about oneself, losing confidence, and being unnecessarily pessimistic or constantly feeling helpless. In certain instances, conditions are characterized by impairment of intellectual functions, the experience of shallow and unstable emotions, and difficulty in adapting to one's environment.

Neurosis. One of the two major categories of emotional maladjustments, classified according to the predominant symptom of defense mechanism. Anxiety is the chief symptom, with the possibility of some impairment of thinking and judgement. It usually represents an attempt at resolving unconscious emotional conflicts in a way that diminishes the individual's effectiveness in living.

Personality disorder. A group of disorders characterized by pathological trends in personality structure. In most instances, this condition is manifested by a lifelong pattern of abnormal action or behavior, often evident from adolescence or earlier. It may show itself by lack of good judgement or poor relationships with others, accompanied by little anxiety and no personal sense of distress.

Psychosis. A severe impairment of mental functioning that interferes grossly with an individual's ability to meet the ordinary demands of life. It is generally characterized by severe emotional disturbance, profound introspection, and withdrawal from reality.

MANAGEMENT TERMS

Cost effectiveness. A basic evaluation methodology often employed by CMHCs to identify effectiveness and efficiency relative to key program components, cost, and the goals desired from each.

MIS. This management tool (known as the Management Information System) frequently provides:

- Program feedback to compare outcomes with objectives
- Factual information to enable the general public to learn about quality and quantity of services
- The basis for analysis and planning that enables management to pose cost effectiveness alternatives

Monitoring. Any of various mechanisms or procedures for checking or regulating the performance of various components of a program; current approaches in the CMHC program are through the use of site visits and the annual biometry inventory form which evaluates the effectiveness and efficiency of programs and accessibility and responsiveness to community needs.

Ombudsman. A public official or representative appointed to investigate citizens' com-

plaints against local or national government agencies and programs that may be infringing on the rights of individuals.

Professional Standards Review Organization (PSRO). An entity which applies collective professional judgement to determine and monitor the necessity, quality, and effectiveness of health and mental health services. Its major function is a managerial one designed to develop and ensure the effective and efficient distribution of health and mental health services within resource availability constraints and with the least interference of bureaucratic control.

Provider of service. An individual or organization whose primary current activity is the provision of health, mental health, or human service care to individuals or is involved in the administration of facilities or institutions in which such care is provided. Usually such individuals have received professional training in the provision of care or in administration, and are licensed or certified for such provision or administration.

PERSONNEL TERMS

Since States differ in their requirements for certification of these professions, it is advantageous to become knowledgeable about the criteria of your individual State.

Clinical Social Worker. A person with specialized postgraduate training in social work, as well as in certain aspects of psychiatry, who utilizes techniques pertinent to both fields. These individuals are concerned with helping people find ways of dealing with mental health problems. Tasks frequently involve working with individuals, families, groups, and communities to plan and provide services for the disturbed or maladjusted.

Requirements—A Master's degree in Social Work. A Doctorate in Social Work (D.S.W. or Ph.D.) is offered at many graduate schools for those desiring to teach, engage in research, or acquire advanced knowledge and skills.

CMHC Director or Mental Health Administrator. Provides administrative direction and coordination for the CMHC programs. Is responsible for providing for the most efficient and effective use of limited resources.

Requirements—Full-time individual who is qualified by training *and* experience as a mental health professional, a mental health administrator, or a health administrator with a specialization in mental health.

Occupational Therapist. An individual specifically trained and certified to practice the use of selected occupations for therapeutic and rehabilitation purposes. Concerned with providing guidance and development of skills in areas that will aid a patient after hospital release. Additionally supplements psychotherapy, bridging the gap between hospital and community living and creating a treatment environment.

Requirements—B.A. degree with curriculum specialization and 6 to 9 months of clinical experience. One must additionally pass a national examination given by the American Occupational Therapy Association and be registered.

Psychiatrist. A specialist in psychiatry, specifically, a graduate of a medical school, licensed to practice and to prescribe medications, with postgraduate training in the detection, diagnosis, and treatment of mental and emotional disturbances. The disturbances may be of physical or emotional origin or result from a situational crisis.

Requirements—Four years of approved residency training and boards

Psychiatric and Mental Health Nursing Specialists. The specialist in psychiatric and mental health nursing is distinguished by: graduate education; supervised clinical experience; indepth knowledge, competence, and skill in the practice of psychiatric and mental health nursing. Is a licensed, professional nurse who has demonstrated expertise in psychiatric and metnal health nursing practice through a formal review process.

Requirements—A masters degree in psychiatric-mental health nursing.

Psychologist. A psychologist in a CMHC may, depending on assignment, assume a variety of duties depending on background, training, and experience.

1. Clinical Psychologist—Works in the areas of personality assessment, and prevention and treatment of emotional

and mental disorders. One would usually work with individuals, groups, or families who have personal, social, emotional, or behavior problems.

2. Counseling Psychologist—Concerned with helping people deal with their environment.
3. Educational/School Psychologist—Concerned with understanding how people learn and what motivates them to achieve.

Requirements—Graduate study in psychology leading to a Masters degree and in many cases a doctoral degree (Ph.D.)

Paraprofessionals. A trained aide who assists a professional person.

Appendix B

Common Abbreviations

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
CA	Catchment Area
C&E	Consultation and Education
CMHC	Community Mental Health Center
DHEW	Department of Health, Education, and Welfare
DMHSP	Division of Mental Health Service Programs, NIMH
CPP	Citizen Participation Program
CSP	Community Support Program
ES	Emergency Services
GAO	Government Accounting Office
HSA	Health Systems Agency
HSP	Health Systems Plan
HSO	Human Service Organization
JCAH	Joint Commission on Accreditation of Hospitals
MHA	Mental Health Association
MHSS	Mental Health Services Support Branch, NIMH
MIS	Management Information System
NAMHC	National Advisory Mental Health Council
NCCMHC	National Council of Community Mental Health Centers
NIMH	National Institute of Mental Health
OMB	Office of Management and Budget
OPD	Outpatient Department
PAB	Professional Advisory Board
PH	Partial Hospitalization
PSRO	Professional Standards and Review Organization
P.L. 94-63	Public Law 94-63 - CMHCs Act
RO	Regional Office
SHPDA	State Health Planning and Development Agency
SMHA	State Mental Health Authority
SHCC	Statewide Health Coordinating Council

Appendix C

The Federal CMHC System

The Community Mental Health Centers Act, as amended by Public Law (P.L.) 94-63, assigns authority for carrying out the Community Mental Health Centers Program to the Secretary of the Department of Health, Education, and Welfare. The Secretary has delegated this authority to officials of the department who are more directly involved with the CMHC program on a day-to-day basis. Generally those authorities concerned with policy setting are assigned to headquarters officials, and those concerned with implementation actions are assigned to officials in the regional offices.

Citizens and boards should know the location of authority for receiving and reviewing grant applications, approving grant awards, and maintaining surveillance of grantee institutions. The authority for these actions has been delegated to the regional health administrator in each of the 10 DHEW regional offices. Although the regional health administrator is assisted in these processes by professional and technical specialists, final decisions are his/her responsibility. In the process of approving grants the law does require, however, that there be a recommendation of approval from the National Advisory Mental Health Council.

The National Advisory Mental Health Council is composed of 12 members who are selected to represent a broad spectrum of mental health interests throughout the country. These members, appointed by the Secretary, meet four times a year to deliberate on major policy issues and to advise the director of the National Institute of Mental Health on these and other issues. At three of these meetings, the council reviews actions on pending grant applications and makes recommendations on each of them for approval or other appropriate disposition. A grant may not be approved unless this council has so recommended.

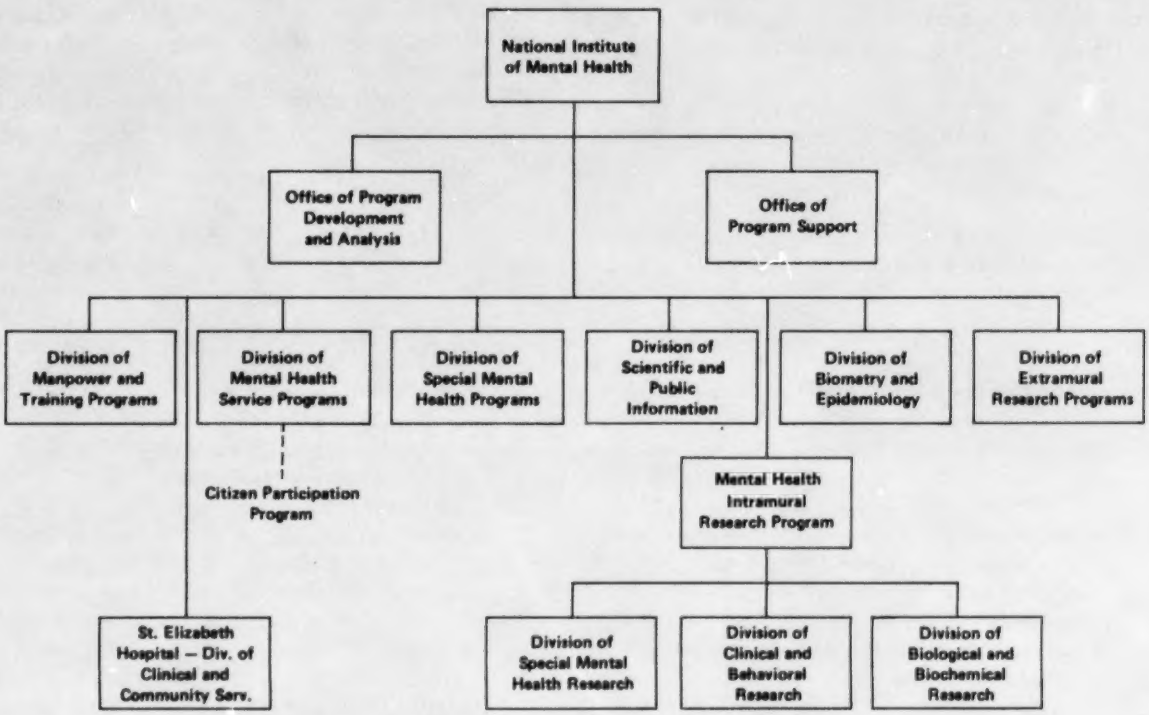
These are the Federal entities most prominent in direct involvement with federally funded community mental health centers. There are, however, others who influence the process and its outcome through policy determinations, the promulgation of regulations, the allocation of funds, and other managerial and administrative actions. Among these is the National Institute of Mental Health which is the headquarters organization with primary responsibility for mental health programs. A variety of other organizations in the headquarters structure also have some influence in the process.

The National Institute of Mental Health is the Federal Agency within the Department of Health, Education, and Welfare that administers Federal mental health programs. It is an operating agency of the Public Health Service. Its basic mission is to develop knowledge, manpower, and services to treat and rehabilitate the mentally ill, to prevent mental illness, and to promote and sustain mental health.

Research is carried out by the Institute's research program and is supported by grants awarded to investigators in the Nation's universities, hospitals, and other institutions and agencies. Training programs for the development of skilled manpower in the mental health professions and allied fields provide training support to individuals through grants to institutions and through research fellowships. Financial and technical assistance to States and localities through several programs aids the develop-

ment of community mental health services to benefit people everywhere.

Underlying the extreme diversity of studies and projects supported by the National Institute of Mental Health is a clear unity of purpose: that of adding to scientific knowledge of the forces within and around the individual which affect or dictate his


National Institute of Mental Health
Office of Program Development and Analysis
Office of Program Support
Division of Manpower and Training Programs
Division of Mental Health Service Programs
Division of Special Mental Health Programs
Division of Scientific and Public Information
Division of Biometry and Epidemiology
Division of Extramural Research Programs
Citizen Participation Program
Mental Health Intramural Research Program
St. Elizabeth Hospital — Div. of Clinical and Community Serv.
Division of Special Mental Health Research
Division of Clinical and Behavioral Research
Division of Biological and Biochemical Research

emotional and mental health, and the application of this knowledge in effective treatment and prevention services.

There are other Federal laws and regulations which influence some aspects of the system for Federal assistance to community mental health centers and sometimes have a direct impact on the centers and their operations. These are the Federal agencies having broad national responsibilities for such matters as housing, civil rights, health services delivery, environmental issues, the control of Federal funds, and oversight on the performance of Federal agencies.

While there are numerous Federal entities involved, the regional health administrator and his staff at the regional offices serve as the primary source of communication between the Federal Government and the community mental health centers. For assistance and information centers, applicants and other interested parties should initiate inquiries through this resource in the appropriate regional office. A listing of regional offices indicating the States included in each region as well as key contact persons follows.

Planning Functions in the CMHC Service Delivery System

Planning function	Agency responsible	Authorizing legislation
Divide the state into CMHC catchment areas	State Mental Health Authority (SMHA)	P.L. 94-63
Periodically review CMHC catchment area boundaries	SMHA, State Health Planning and Development Agency (SHPDA)	P.L. 94-63
Determine relative need of different areas for CMHCs and community mental health services	SMHA, Health Systems Agencies (HSA)	P.L. 94-63
Inventory existing mental health services in the state	SMHA, HSA, SHPDA (institutional services)	P.L. 94-63 P.L. 93-641
Analyze existing community mental health services according to specified criteria	SMHA	P.L. 94-63
Develop a plan for CMHC construction and community mental health service provision	SMHA, HSA, SHPDA, Statewide Health Coordinating Council (SHCC)	P.L. 94-63 P.L. 93-641
Determine the priorities for CMHC projects by relating relative need to the inventory of resources	SMHA	P.L. 94-63
Review and comment on, deny, or approve proposed uses of CMHC funds according to state CMHC plan or HSA plan	SMHA, HSA	P.L. 94-63 P.L. 93-641
Review and approve or disapprove state CMHC plan	SHCC, Department of Health, Education and Welfare (HEW)	P.L. 93-641 P.L. 94-63
Review and approve or disapprove state health plan	SHCC, HEW	P.L. 93-641
Administer state certificate-of-need program	SHPDA	P.L. 93-641
Development of minimum standards for the maintenance and operation of CMHCs	SMHA	P.L. 94-63

STATE AND LOCAL RELATIONSHIP

The governmental structure of each State includes provisions of administering health and mental health services throughout the State. Although there are variations of the structure among the States, each has designated a State Mental Health Authority who, among other assignments, is responsible for community mental health program activities assigned to the State by the Community Mental Health Centers Act. These include responsibilities for developing and administering the State Mental Health Plan, establishing and implementing statewide standards for mental health services, setting priorities for establishing new centers based on an assessment of relative need among catchment areas, and commenting on applications being submitted for community mental health center grants. The State Mental Health Authority has a major influence on the development of effective community mental health services within the State and generally is assigned broad authorities over the management of institutions concerned with mental illness and mental health and over the development of mental health services at the community level. SMHA may also promote CMHC applications, consult with applicants, and participate in monitoring.

The importance of mental health services is accorded special attention in the State structure. Close collaboration and coordination of mental health services in the State with other health services, social services, and educational and law enforcement functions are also important. The Community Mental Health Centers Act recognizes this necessity and includes requirements and incentives to foster coordination.

The Act also includes provisions to assure community endorsement of and participation in the activities of the community mental health center. Examples are the requirements for community representation on the center's governing board, community participation in annual reviews, and periodic public reporting of the center's activities. In addition to these formal mechanisms, one cannot overlook the impact of established political institutions and influential individuals and groups interested in the affairs of the community or its political and social subdivisions.

It is evident from this brief overview that there is a broad range of Federal, State, and local entities influencing the scope and structure of a federally funded community mental health center. Its program of services and basic structure are defined in Federal Law; the population area for which it is responsible is designated in the State Mental Health Plan; its day-to-day activities are subject to community control and scrutiny; and it is dependent on Federal, State, and local community resources to carry out its mission. The center must maintain a constant awareness of these influences as it proceeds to carry out its primary mission to make available to the community a program which provides a comprehensive series of preventive, diagnostic, therapeutic, and restorative mental health services.

It is the goal of the Federal Government and State agencies to assist and guide centers in developing and maintaining high standards of excellence in carrying out this mission.

REGIONAL OFFICES

Department of Health, Education, and Welfare Directors,
Division of ADAMHA Programs:

Region I, Boston, Mass.

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John F. Kennedy Federal Building
Room 1409
Boston, Massachusetts 02203
Phone: 617-223-6825

Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Region II, New York, N.Y.

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New Jersey
New York
Puerto Rico
Virgin Islands

Region III, Philadelphia, Pa.

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District of Columbia
Maryland
Pennsylvania
Virginia
W. Virginia

Region IV, Atlanta, Ga.

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Phone: 404-242-2000

Alabama
Florida
Georgia
Kentucky
Mississippi
N. Carolina
S. Carolina
Tennessee

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Louisiana
New Mexico
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Texas

Region VII, Kansas City, Mo.

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Missouri
Nebraska

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Colorado
Montana
N. Dakota
S. Dakota
Utah
Wyoming

Region IX, San Francisco, Calif.

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Phone: 415-556-2215

Arizona
California
Hawaii
Nevada

Region X, Seattle, Wash.

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Arcade Plaza
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Seattle, Washington 98101
Phone: 216-399-0524

Alaska
Idaho
Oregon
Washington

Appendix D. Sample Board Constitution and Bylaws

Constitution and Bylaws of the Advisory/ Governing Board of the Community Mental Health Center

SAMPLE

CONSTITUTION

ARTICLE I: NAME AND OBJECTIVES:

(a) The Name of this body shall be the Governing/Advisory Board of the _____ Community Mental Health Center.

(b) The Objectives are: to involve the community of _____ Community Mental Health Center catchment area in the governance of the _____ Community Mental Health Center; to help the community develop a mental health system capable of meeting all the major mental health needs of the community with the _____ Community Mental Health Center as the keystone of this system; to unite community members of all social groups in coming to grips with mental health problems, so as to contribute to the development of a sound community.

ARTICLE II: MEMBERSHIP AND ELECTION:

(a) The Governing/Advisory Board shall be composed of twelve (12) members, who are eighteen (18) years of age or older, who are residents of the catchment area, and who are members in good standing of the community. Over half of the members of the Board shall be persons who are not providers of health care, providers defined in P.L. 94-63. The Director of the _____ Community Mental Health Center shall be a member of the board ex-officio.*

(b) Election to the Governing/Advisory Board must be carried out no sooner than three (3) months and no later than two (2) weeks before the beginning of the term of office of the Board members. Names of the representatives elected shall be given in writing to the Board Secretary. No one shall be seated as a member of the Board until he or

*Whenever used in this document *ex-officio* means membership without vote or the power to make motions from the floor, but without other restrictions [with the exception stated in Article II(h) of the Bylaws].

she attends a meeting of the Board and does not become a member thereof until seated.

(c) Governing/Advisory Board members shall be elected by the local citizens once every two years, in odd numbered years, for a two-year term. The term shall start in September with the annual organization meeting of the odd-numbered year and shall continue until the annual organization meeting of the next-odd-numbered year. However, if for any reason, the annual organization meeting cannot be held in September, the new members are not seated and the previously elected and seated members remain as Board members until the annual organization meeting is held. Such meeting must be held as soon as possible in case it has had to be posponed for any reason.

(d) Vacancies in Board membership positions, however created, shall be filled by election, except that the chairperson of the Board shall appoint a representative to fill the vacancy in case the Board fails to have a quorum at the meeting when the vacancy should be filled. The member filling the vacancy shall serve for the remainder of the unexpired term.

(e) Conflict of Interest: No paid employee of the _____ _____ Community Mental Health Center may serve on the Governing/Advisory Board except that the Community Mental Health Center Director shall be an *ex-officio* member and other employees may serve on committees *ex-officio* as officially designated. Except for the _____ Community Mental Health Center Director, no _____ employee in an administrative position may serve on the Governing/Advisory Board.

(f) Although nonresidents of the catchment area may not serve on the Governing/Advisory Board, such persons may serve on Board Committees, provided that no committee shall be composed of a majority of nonresidents.

(g) (See amendment)

(h) A vacancy shall be created automatically in the event of a Governing/Advisory Board member resigning local membership or by not being reelected to the Board or by losing good standing. In any such case the Secretary of the Board must notify the Governing/Advisory Board in writing.

ARTICLE III: OFFICERS:

(a) *Officers* shall be Chairperson, Vice Chairperson, Secretary and Treasurer.

(b) *Duties* shall be those usual to each office except that other duties may be assigned by the Board at its annual organization meeting.

(c) *Officers* shall be elected by the Governing/Advisory Board at its annual organization meeting, once every year in September. The term of office shall be for 1 year, or until the election of new officers. In case the annual organization meeting cannot be held in September, for any reason, the previously elected officers shall continue to serve until the election is held. Members elected to office in the annual organization meetings shall take office immediately upon election.

(d) *No officer* may serve more than two consecutive terms in any *one* office.

(e) *Vacancies* in office shall be filled for the remainder of the term by the Governing/Advisory Board when such occur for any reason.

ARTICLE IV: MEETINGS:

(a) *The Governing/Advisory Board* shall hold its annual organization meeting in the month of September.

(b) *The Governing/Advisory Board* shall have both regular and special (called) meetings as necessary.

(c) *Special meetings* may be called by the Chairperson with the approval of one officer, in writing, and with at least forty-eight (48) hours notice, i.e., the notice must be given forty-eight (48) hours before the meeting. Also, the Chairperson with similar notice must call a special meeting upon the written request of at least four (4) members—within forty-eight (48) hours of such request or sooner.

(d) *An agenda* shall be prepared for Governing/Advisory Board meetings by the Board Chairperson, or Vice Chairperson when necessary, in consultation with the Center Director or his designee; however, the agenda may be amended by the Governing/Advisory Board in its meeting.

(e) *A quorum* shall be constituted by the attendance of at least a simple majority. Vacant positions on the Board shall not be counted in establishing a quorum.

(f) *Guests,* including staff members, may not be invited to Governing/Advisory meetings without the prior approval of the Chairperson.

ARTICLE IV: POWERS AND RESPONSIBILITIES:

(a) The Governing/Advisory Board shall deal with catchment-wide and center-wide issues and problems. The interests of the subcatchment areas shall be expressed on such issues and problems through the local representatives to the Governing/Advisory Board. (The Memorandum of Understanding has spelled out Governing/Advisory Board authority and responsibility, and parts of this document should be included in the Constitution and By-Laws as soon as it is feasible.)

The responsibilities of the Governing/Advisory Board shall be as follows:

ARTICLE V: RESPONSIBILITIES. Aside from those inherent in Items I through IV above, responsibilities are:

(a) To give direction, suggestions, and recommendations to the center director and/or the appropriate staff through meetings, committees, and otherwise.

(b) To work to improve the Center, based on the Board's specific authority as directed in P.L. 94-63 to:

(1) approve the annual budget
(2) establish general policies for the center
(3) approve the selection of a director for the center
(4) evaluate the performance of the center director
(5) meet at least once a month

(c) To interpret the community to the Center and the Center to the community;

(d) To monitor and champion the interests of the community as regards the provision of both preventive and treatment services—within the Center, locally, and on the State and National levels;

(e) To help in the assessment of community needs and problems relevant to community mental health.

BYLAWS

ARTICLE I: COMMITTEES:

(a) Ad Hoc Committee chairmen shall be appointed by the Chairman, with Governing/Advisory Board approval; ad hoc committees are governed by the rules below [(e) through (h)] with the exception noted.

(b) Standing committees may be created by the majority vote of the Board, provided a quorum is present.
There shall be the following standing committees:

Board Membership
Administrative or Management
Program
Personnel
Finance
Community Relations
Public Relations

All standing Committees shall be governed by the rules below [(e) through (h)].

(c) The responsibility of dealing with the overall administrative operational issues of the _____ Community Mental Health Center shall be exercised by the entire Governing/Advisory Board in its relationship with the Center Director.

(d) The Board thought the above structure should deal with center-wide (_____ CMHC), catchment-wide, and Service issues (problems; these concern priorities, policies, personnel, program (services), or other aspects of the Center's functioning.

(e) The Chairperson of each committee shall be designated by the Board Chairperson with the approval of the Board.

(f) The Committee Chairperson chooses committee members subject to the approval of the Governing/Advisory Board.

(g) *Ex-Officio:* The Governing/Advisory Board Chairperson is an *ex-officio* member of each committee (and has no vote in the committee except in the case of a tie vote).

(h) The _____ Community Mental Health Center Director, in consultation with the Governing/Advisory Board may assign staff consultants to the Board. Such consultants are not *ex-officio* and do not have the right to vote or to put a motion on the floor.

ARTICLE II: AMENDING PROCESS:

(a) The Constitution may be amended by a two-thirds (2/3) vote of the Governing/Advisory Board in a regular or special meeting, i.e., two-thirds (2/3), rounding off fractions, of those present, provided there is a quorum.

Amendments may be proposed in writing by the Board Chairperson or by four (4) or more Board members.

Such proposals must be submitted in writing to the Governing/Advisory Board secretary and voted upon in the next regular or special meeting, provided that there is time for all members to receive amendments in writing no later than seven (7) days before the meet-

ing. Otherwise, the vote must be taken in the next meeting. Such a meeting must be held no later than sixty (60) days after the Secretary has received the amendments.

(b) *Bylaws* may be amended in any regular or special meeting by a majority vote of the Governing/Advisory Board members present, provided there is a quorum. Copies of the Amendment(s) to be offered must be included in the notice of the Board meeting, otherwise, no Board action may be taken.

ARTICLE III: ANNUAL REPORT:

(a) An annual written report shall be submitted by the Governing/ Advisory Board to the local community no later than one (1) month before the annual organization meeting.

Appendix E

Legislative History

Chronology of Important Federal legislation affecting the development of the federally supported CMHCs Program:

1946 *National Mental Health Act, 1946*

This Act amended the Public Health Services Act of 1944. It established a National Mental Health Advisory Council to be composed of the Surgeon General of the United States and six other individuals. Three general purposes were set forth: (1) fostering and aiding research relating to the cause, diagnosis and treatment of neuropsychiatric disorders; (2) providing for training of professional personnel through the award of fellowships to individuals and grants to public and nonprofit institutions, and (3) aid to the States, through grants and other assistance in the formation and establishment of clinics and treatment centers, and the provision of pilot and demonstration studies in the presentation, diagnosis, and treatment of neuropsychiatric disorders.

Of highlight were the three provisions which provided for training grants to institutions as well as fellowships to individuals; the concept of a State control program in psychiatric disorders; and the establishment of the National Institute of Mental Health under the auspices of the Public Health Service.

1955 *Mental Health Study Act, 1955*

This Act directed the Joint Commission on Mental Illness and Health, under grants administered by the National Institute of Mental Health, to analyze and evaluate the human and economic needs and resources of the mentally ill people of America and make recommendations for a national mental health program. The final report of the Commission was published in 1961. It recommended that Congress appropriate an additional $4.2 million in 1962 to support the development of comprehensive mental health planning in each of the States.

1963 *P.L. 88-164. The Mental Retardation Facilities and CMHCs Construction Act*

Provided Federal funds for the construction of CMHCs and research center and facilities for the mentally retarded. This law led to direct local support for mental health services. It authorized grants for the construction of public and nonprofit private CMHCs, becoming the basis for a new philosophy of treatment offering a full range of comprehensive mental health services available in the patient's own community.

Later amendments (amended 1965, 1967, 1970, 1975) provided grants for staffing of these centers.

1965 Amendments—Provided for grants to aid in the initial cost of staffing centers with professional and technical personnel.

1967 Amendments—Extended, through fiscal year 1970, appropriations for the construction and staffing of CMHCs, also making possible the acquisition of existing buildings for use as centers.

1968 Amendments—Added new parts C & D for the CMHC Act providing for Federal grants for the construction and staffing of specialized facilities for the prevention and treatment of alcoholism and narcotic addiction.

1970 Amendments—Extended the basic Centers Program and those related ones for the prevention and treatment of alcoholism and narcotic addiction through fiscal year 1973. The Act also authorized a new program for children's mental health facilities and services. It additionally provided for payment of a higher Federal share of costs for such programs in urban or rural poverty areas and permitted a portion of the staffing appropriation to be used for the initiation and development of new programs in these areas.

1970 *Comprehensive Drug Abuse, Prevention, and Control Act of 1970*

Amended the CMHCs Act by broadening the nature of drug treatment services to include all kinds of drug abuse as well as narcotic addiction, and providing new programs of special project grants for (1) drug abuse treatment and (2) drug abuse education.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

Amended Part C of the Community Mental Health Centers Act, "Alcoholism," by adding a section 247 on "Grants and Contracts for the Prevention and Treatment of Alcohol Abuse and Alcoholism." The Secretary of Health, Education, and Welfare, acting through the National Institute on Alcohol Abuse and Alcoholism (then a part of NIMH), was authorized, for the purpose of prevention, treatment, and rehabilitation, to make grants to public and private nonprofit agencies, organizations and institutions, and individuals, to conduct demonstration, service, and evaluation projects; to provide education and training; to provide programs and services in cooperation with schools, courts, penal institutions, and other public agencies; and to provide counseling and education activities on an individual or community basis.

This Act also amended the Community Mental Health Centers Act to expand the authority for grants to public or nonprofit private agencies or organizations for the "construction of specialized facilities (including posthospitalization treatment facilities) for the treatment of alcoholics requiring care in such facilities. As amended, the Act authorizes such grants for the "construction or leasing of specialized facilities including facilities for emergency medical services, intermediate care services, or outpatient services, and posthospitalization treatment facilities."

1972 *The Drug Abuse Office and Treatment Act of 1972*

Amended Community Mental Health Centers Act by authorizing funds for the staffing of community mental health centers (to meet additional staffing costs occasioned by the enforcement of new drug program requirements). This Act also created a National Institute on Drug Abuse within the National Institute of Mental Health, to become effective at a later date. Among other things, the Act required all community mental health centers funded after June 30, 1972 to make treatment available to drug abusers, if such services were not otherwise available.

1975 *Public Law 94-63*

Enacted July 29, 1975, was an Act "to amend the Public Health Service Act and related health act to revise and extend the health, revenue sharing program, the family planning programs, the community mental health centers program, the program for migrant health centers and community health centers, the National Health Service Corps program, and the programs for assist-

ance for nurse training, and for other purposes." Title III of this Law, the "Community Mental Health Centers Amendments of 1975," authorizes appropriations for and extends the Community Mental Health Centers Program for fiscal years 1976 and 1977. Among its most important features are: an expanded scope of services required to be provided by every center; modified grant programs paying for costs of operations (not staffing) assistance; facilities assistance (not construction only) and planning of CMHCs; new programs for conversion of existing grantees to the new program; financial distress assistance for centers whose operations (or staffing) grants have terminated and which meet certain conditions; a separate earmarking of funds for consultation and education; and the establishment within the National Institute of Mental Health of a National Center for the Prevention and Control of Rape.

1977 *Amendments—P.L. 95-83*

Provided for a 1-year extension of the definition and the requirements for a comprehensive CMHC as a condition of obtaining or continuing grant support as previously spelled out in P.L. 94-63. It additionally allowed three grants to Staffing and Part F (Children's Services), rather than two, in meeting the Section 201 requirements of P.L. 94-63; also provided for a grant application review cycle of 120 days replacing the earlier cycle of 90 days, i.e., applicant must be notified of approval/disapproval within 120 days of submission of the application.

Appendix F

Selected Publications of the National Institute of Mental Health for Citizens and Boards

5600 Fishers Lane
Rockville, Maryland 20857

Public Inquiries, telephone (301) 443-4513

A courtesy copy is available upon request from NIMH. Quantity copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (minimum charge, $1 per mail order). *Do not send money to NIMH.* Mental Health Statistics are available from the Division of Biometry and Epidemiology, (301) 443-4862.

A Citizen's Guide to the CMHC Amendments of 1975 ADM 76-397
ADAMHA Leaflet ADM 76-129
ADAMHA—Meeting America's Needs ADM 75-239
ADAMHA Research Grant Awards FY 1975 ADM 76-319
An Annotated Bibliography on Mental Health in Schools ADM 76-107
Behavior Modification: Perspective on a Current Issue ADM 77-202
Bibliography on Racism ADM 76-318
Careers in Mental Health ADM 75-250
Child Abuse and Neglect Programs; Practice I Theory ADM 78-344
Community Based Correctional Programs, Models, and Practices ADM 74-56
A Consumer's Guide to Mental Health Services ADM 77-214
Criminal Commitments and Dangerous Mental Patients ADM 77-331
Directory: Federally Funded Community Mental Health Centers ADM 75-258
El Centro (Spanish Version) ADM 77-398
Facts about College Mental Health ADM 77-72
Federally Funded CMHC Directory 77 GPO 254-049
Functions of the Police ADM 75-260
Guide to Mental Health Education Materials ADM 77-35
Individual Treatment Planning for Psychiatric Patients ADM 77-399
Integrated Management Information Systems for Community Mental Health Centers ADM 77-165
It Can't Be Home ADM 76-313
It's Good to Know About Mental Health ADM 77-67
Latino Mental Health: A Review of the Literature ADM 76-113
Latino Mental Health: Bibliography and Abstracts ADM 76-317
Maintenance of Family Ties of Long Term Care Patients ADM 77-400
The Mental Health of the Child ADM 75-251
The Mental Health of Rural America ADM 76-349
Mental Health at School ADM 76-105
Mental Health Program Reports 6 ADM 75-256
Mental Illness and Its Treatment HSM 73-9056
NIMH in Brief ADM 77-363
National Institute of Mental Health Support Programs HSM 72-9044
New Dimensions in Mental Health: The Federal Government and Psychiatric Education: Purposes, Problems, and Prospects ADM 77-511

New Dimensions in Mental Health: Making It in 19th Century Urban America ADM 77-342

Private Funds for Mental Health Research ADM 75-134

Program Evaluation in State Mental Health Agencies ADM 77-310

Rape Prevention: A New National Center ADM 77-410

Serving Mental Health Needs of the Aged Through Volunteer Services ADM 76-269

Trends in Mental Health: Unlocking the Mystery of Mental Illness ADM 76-407

A Working Manual of Simple Program Evaluation Techniques for Community Mental Health Centers ADM 76-404

Appendix G

Additional Resources

National

Mental Health Association
National Headquarters
1800 North Kent Street
Arlington (Rosslyn), Virginia 22209

National Center for Voluntary Action
1214 16th Street, N.W.
Washington, D.C. 20036

National Council of Community Mental Health Centers
2233 Wisconsin Avenue, N.W.
Suite 322
Washington, D.C. 20007

National Association of State Mental Health Program Directors
1001 - 3rd Street, S.W.
Suite 116
Washington, D.C. 20024

Joint Commission on Accreditation of Hospitals
Accreditation Council for Psychiatric Facilities
875 North Michigan Avenue
Chicago, Illinois 60611

American Psychiatric Association
1700 - 18th Street, N.W.
Washington, D.C. 20009

American Psychological Association
1200 - 17th Street, N.W.
Washington, D.C. 20036

American Nurses Association
1030 - 15h Street, N.W.
Suite 408
Washington, D.C. 20005

American Occupational Therapy Association
6000 Executive Blvd.
Suite 200
Rockville, Maryland 20852

National Association of Social Workers
1425 H Street, N.W.
Washington, D.C. 20005

United Way of America
801 North Fairfax Street
Alexandria, Virginia 22314

State

Health and Mental Health Authorities (these appear under a variety of names, according to the organization of the various State departments).
Examples:

a. State Department of Mental Health
b. Department of Health Services
c. Department of Human Resources
d. Department of Public Institutions, and Agencies
e. Department of Hospitals and Institutions, etc.
f. Mental Health Associations

Various State, public, and private universities and colleges

Board of Examiners

Psychologists

Social Workers

Nurses

Psychiatrists

Local

Mental Health Associations

Public and private educational institutions—universities, colleges, and community colleges

United Way

*U.S. GOVERNMENT PRINTING OFFICE : 1980 O-311-246/6082